Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State
Registrar Amend#18.PerFHPGC6-8-11cr 9501 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 29 ^D2011 Physician/ Miguel 1420 Α. Reid Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomey If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** . 1<u>972</u> Months Min July 8 1 🛛 M 2 🗆 F Hours 213-13-4872 Yrs. Wash., DC **Director** 38 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 18711 Sparkling Water Drive, Unit K 20874 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Married ☐ Yes 2 XNo þ 5-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced er than "natur , the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Seconday (0-12) 12 life. DO NOT use retired) College (1-4 or 5+) Dept. of Trans. Clerk Mail Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, # once. Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Jackson Maureen C. Craig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2007 Gaither Street Temple Hills, MD, 20748 Pamela Craig/aunt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Resurrection Cemetery 6/10/11 4 Donation 5 Other (Specify) Clinton, MD 22. Name and Address of Facility Hodges & Edwards F.H. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, MD. 20746 Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shork, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) that the death certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Quemo P.O. Box 68760 as attending IF FEMALE: ate has been signed by the attending page 2 should be detached for use. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No 2 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Cartifyin (Check only one) Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature ar 00 S7574 Name and address of person who completed cause of death (Item 23a) (Type, Print) Millrun Drive, Derwood, Mary land Heshmat MD 7133 31. Date filed (Month JUNO 6 2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician/ 2011 9:12 Alexander Rodriguez 30 ам May Medical 4c. County of Death
Montgomery 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Silver Spring Holy Cross Hospital 9. Birthplace (State or Foreign Country) 8. Date of Birth If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Year) 2011 Funeral (Month, Day, May 30 1 XM 2 | F Months 149 Hours O Yrs **Director** None May Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20902 #14 12112 Shorefield Court, death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ♣No Black, White, etc. Specify: White permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event. The Madical Exercises 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specify: Bolivian & If Yes Give 3 Widowed 4 Divorced Completed Honduran Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A None None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marlene Gamboa Melvin Andres Rodriguez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 12112 Shorefield Ct., #14, Silver Spring, MD 20902 Marlene Gamboa/Mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Metropolitan Crematory 1 ☐ Burial 2 🔀 Cremation 3 🔀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 3 2011 Alexandria, VA 22. Name and Address of Facility rancis J. Collins Funeral Home Inc. Signature of Funeral Service Licenses Silver Spring,MD 20901 500 University Blvd. W., Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Extreme Prematurity at 22 Weeks Gestation Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 🗌 No Yes 2X No 1 L Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 🙀 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 □ only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

JUN 1 0 2011

31. Date filed (Month, Day, Year

1500 Forest Glen Road, Silver Spring, MD 20910 Chrysanthe Gaitatzes, 32. Registrar's Signatu

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 19503 State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Eda Rabineau June 6, Physician/ 2011 10:00 A M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Silver Spring 117 Eldrid Drive 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Social Security Number **Funeral** 1 □ M 2 🏝 F Days Hours /2371336 ar) MaryTand 81 218-26-3163 Director Usual Residence of Decedent 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director Silver Spring MD Montgomery 1X Yes 2 No 10g, Citizen of What Country? 10e. Street and Number 10f, Zip Code Funeral United States 20904 117 Eldrid Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc.
White þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 ₺ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Private Accounting Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hannah "Unknown" Kaufman Falk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 144 Martin Creek Lane Hardin, KY 42048 Renee K. Rabineau-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery, crematory or other place)
United Hebrew Cemetery 6/10/2011 Baltimore, Maryland 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, MD 20852 . Signature and all Prvice Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between 3 Months Immediate Cause (Final ∲Nysician/ Gastric Carcinoma Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underly in Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition. that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Osteoporosis, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Degenerative Disk Disease autopsy performed? Yes 2 K No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 🗌 Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural work? 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only ong 29d. Date signed (Month, Day, Year) nd title of certifier 29c. License number 29b. Signature June 6, 2011 D14440 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silver Spring, MD 20904 11161 New Hampshire Avenue, #201

State Registrar Jerome J. Schnapp, MD

WIN 1 0 2011

31. Date filed (Wonth, Day, Year)

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 05/27/2011 Year 5:18 P M BETTY ANN RYAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Laurel Laurel Regional Hospital If Under 1 Year Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. 1 □ M 2 🛛 F 0272271954 Director 216-60-6903 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Prince George's MD Laurel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 7622 East Arbor Court 20707 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc þ 1 X Never Married 2 Married hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XIo Specify: 3 Widowed 4 Divorced Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 Elementary/Seconday (0-12) College (1-4 or 5+) vears Manager Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) anould be filt th and Mental H ပ Margaret May Watson Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Clarence D. Ryan-brother 8447 Beacon Avenue S, Seattle, Washington 98118 20c. Location - City or Town, State 20a. Method of Disposition Ob. Place of Disposition (Name of cemetery, crematory or other place) Cremation 3 Removal from 5 Other (Specify) 1 XBurial of 06/04/11 Gate Silver Spring, MD Heaven Cem. f Juneral Service Licen 22. Name and Address of Facility 21. Signatur Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or coord shock, or heart failure. List only o s that caused the death. e on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death €nysician/ Acute Mi disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypoxia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (prisease or imjury Due to (or as a consequence of): Acute respiratory failure that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Advance multiple sclerosis Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death the 9 Unknown b signed t Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be prior to completion of cause of death? page 2 autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No မ 1 🗶 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ipleted filled in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05/27/2011 D12962 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zorayda Lee-Llacer, MD 7300 Van Dusen Road, Laurel, MD 20707 31. Date filed (Month 2. Registrar's Sign State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 25 2011 May Marina P. Rappoport Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner **Bethesda** Montgomery Suburban Hospital 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 7. Age (In vrs. last birthday) Country)
Russia **Funeral** Months Hours Min. (Month, Day, 1 □ M 2 🛛 F 63 Yrs. 05/08/1948 Director 053-58-5160 Usual Residence of Decedent 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State with the Maryland Director 1 X Yes 2 ☐ No **Bethesda** Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20817 USA 7401 Westlake Terrace, Apt. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 X Never Married 2 Married ò Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Medical-NIH Head Medical Librarian Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) 2 Rachel Levina Pavel Rappoport 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4515 Willard Avenue #1104 South Chevy Chase MD 20815 <u> Alona Bauer/ POA</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State 05/26/2011 Falls Church, VA 4 Donation 5 Other (Specify) National Crematory 21. Signature of Faneral Service Licensee 22 Name and Address of Facility Edward Sagel Funeral Direction Inc. 1091 Rockville Pike Rockville, MD 20852 Blake Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregna 5 Other (specify) Ectopic pregnancy 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death 1 ☐ Yes 2 ¥ 9 ☐ Unknown should be detached the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? Hospital or Attending Physician: The law page 2 performed Yes 2 No certificate 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Division of Vital Be Hospital: 2 No 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: After completed filled in by the fun 1 🗌 Yes 2 🗌 No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one signed (Month, Day, Year) 29b. Signature

State Registrar

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eted cause of death (Item 23a) (Type, Print)

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		Decedent's Name (First, Middle, Last)			timodito or i	Douth	2. Date of De		1	3. Time of Death	
Physici Medi		Av	ine Dena Rose	enberg			Month Jun	e 07, 20	Year	6:42 pm	
Exami		4a. Facility Name (if not institution, give str				r Location of Death	า		4c. County of Death		
	,	Sunrise Assiste 5. Social Security Number 6. Sex	2d Living 7. Age (In yrs.	loat histoslav	S/ If Under 1 Year	4la I	Montgomery 9. Birthplace (State or Foreign				
Funeral Director			M 2 X F 7. Age (117 yrs.		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da July	7 1914	9. Birthplac Country)	oe (State or Foreign Maryland	
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the Moor 28	į	10e. Street and Number	ietg	-	10f. Zip Code	000000		10g. Citizen of V	Vhat Country		
15-0036 72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	Funeral Director	10412 Burnt E	mber Drive			20903			u.s.A	4.	
dea r itel			Was Decedent Ever in U. Armed Forces?			lispanic Origin? (Sp an, Mexican, Puert			e - American k, White, etc.		
o36 s after al", o	d by	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	1	Yes 2 🗓 No	Specify:		Specify:		ite	
15-0036 2 hours after death "natural", or item edical Examiner n	Completed	15. Decedent's Educ (Specify only highest grade	cation		dent's Usual Occup	pation during most of wor	dela a	16b. Kind of Bu			
2121 within 72 giene. er than	E O	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	NOT use retired) Bookk		Kirig	ກຸ	ug Sto	0 h 0	
iled wit I Hygie other	Be	17. Father's Name (First, Middle, Last)			BUUKK		ne (First, Middle,	Maiden Surname			
farylandshould be file and Mental is marked or aumatic ever	은	He	enry Aronson					a Levin	/		
≒ 3⊅ = E		19a. Informant's Name/Relationship (Type			•	and Number or Ru		. ,	, ,	,	
Baltimore, Me pount. Page 1 and 2 sh Department of Health at Important: If item 27 is any injury or other trau once.		Janice Z. Rosenberg			-	ad, Silve					
nor age 1 ent of nt: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cren	sition (Name of natory or other place i and their	^{c⊕)} Cem 06/1	Date	20c. Location -			
Portar Portar		21. Signature of Funeral Service Licensee	1	22						ome, Inc.	
B B B B B		Jary M.	M00709	11	800 New :	Hampshire	e Ave.,	Silver S		, MD 2090	
,		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	cations that caused the dea cause on each line.	th. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory ar	rest,	In	pproximate terval Between	
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Atheroscle Due to (or as a consequence)		Cardiova	scular D	isease		9	nset and Death	
Examiner			Due to (or as a conseq	juence or):							
_ +	iner	Sequentially list conditions, b. if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):							
ecuted and transi	Examiner	Cause (Disease or linjury that initiated events c. resulting in death) Last	Due to (or as a conseq	wonen of							
be exesticant	cal	resulting in deathy East	240 10 (01 43 4 0011364	acrice ory.							
68760 certificate t nding phys	Jedi	d.									
x 68 h certi tendin	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnant 1 Live Birth 2 Live Berth	ancy al death 3 [Ectopic pregnanc	cv		23d. Dat	e of delivery		
Box e death c the attenthed for us	ysici	1 Yes 2 K No	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5	Other (specify)			Moi	nth Da	ay Year	
P.O. that the med by t	Completed by Physician/Medi	Part II. Other significant conditions conti	ributing to death but not re	sulting in the u	nderlying cause gi	ven in Part I.	23e. Did t	obacco use contr	ibute to the c	cause of death?	
dS, l	ed b	Dementia, Failure	e to Thrive,	Breast	Cancer		1 🗆	Yes 2 🗓 No	3 🗆 Probab	oly 4 🗆 Unknown	
COrdaw recast bee	plet	Depression					24a. Was			findings available	
Recate h							perfo	ormed?	leath?		
of Vital Records, ag Physician: The law requires ter this certificate has been signeral director, page 2 should be	To Be	25. Was case referred to medical examiner? 1 Yes 2 X No	spital:		Oth	ace of Death (Chec			7	Assisted	
of V g Phys er this	e: To	27. Manner of Death	1 Inpatient 2 28a. Date of injury	28b. Time of	28c. Injur	4 □ Nursing H y at		dence 6 🛛 Othe		Living	
eath.	ficat	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	M 1 🗆	<br Yes 2 ☐ No					
Division tal or Attendin rs after death. al Director: After de in by the fur	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		eet, factory, office		28f. Location (S City or Tox	Street and Number	r or Rural Ro	ute Number,	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ical	29a. Certifier 1 X Certifying Physici	an: To the best of my know	/ledge, death of	occured at the time	, date and place a	and due to the ca	use(s) and manne	er as stated		
he Ho in 24 l he Ful pletec	Medical	(Check 2 Medical Examiner	r: On the basis of examination Practioner: To the best of m	on and/or invest	igation, in my opinio	on, death occurred	at the time, date a	and place, and due	to the cause	(s) and manner state d.	
Vith vith Com		29b. Signature and title of certifier	Vlan.		29c. License			29d. Date signed			
		▶ K Suyambur				53367		June 08	, 201	<u> </u>	
		30. Name and address of person who com Shaymsundar Rajan,	M.D. 9801	Georgio	L Avenue.	#117. S.	ilver Si	orina. Mi	2090	2	
Sta	te	31. Date filed (Month, Day, Year)	3. Registrar's Signa	are La	N.J.	,					
Registr	ar	JUN 0 9 2011	Cerus F	1. 19							

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9:00 AM ROLAND Physician/ 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rallin Loch Raven Veterans Rehab. Center 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth . Social Security Number 6. Sex Country) **Funeral** Oct. 9 Min Months Days Hours 210-12-2194 84 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🗆 Yes 2 🔀 No MD Carrol1 Finksburg 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 23a USA 21048 3686 Niner Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent Ever III 0.5.

Armed Forces?

1 X Yes 2 □ No
If Yes, Give
Year or Dates. 144-1946 Black, White, etc. þ 1 Never Married 2 Married should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White item 27 is marked other than "natural", other traumatic event, the Medical Exar Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Plumbing 1 3 2 1 12 Plumber Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Lena Gosnell Roland Huff permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 21157 Mrs. Dena Sue Roland (Daughter) 418 Barnes Avenue Westminster. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 5/27/2011 Randallstown, MD Mt. Olive Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licen a PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BLADDER Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate
Cause (Disease or iinjury cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 g Unknown 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform has 1 ☐ Yes 2 ☐ No Yes 2 No this certificate 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? funeral director, Other: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) Medical Certificate: 1 Natural 5 Pending after death. Director: Aff Investigation Accident the 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completed filled in by the determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Unit of the cause (s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 29b. Signature and title of certifie MID

DHMH 17 Rev 7/2009

State

Registrar

3900

31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOCA

31

RAVEN

32. Registrar's Signature

DHMH 17 Rev 1/2001

11-03633 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Bobby Kevin Robinson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day May 14, 2011 1341 hrs Medical Examiner Robinson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll 19 Golden Eagle Court Westminster If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) Months Davs Hours Director 1_X M 2 27 29,1984 New York 066-82-9232 Feb. Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 X No tem 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. New York Kings Brooklyn 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 485 Beriman Street 2R 11208 United States Funeral 11, Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 X Never Married 2 2 X No Yes Black Widowed Divorced If Yes, Give Year Yes 2 XX No specify: Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than " N/A nk Student 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Bobby Johnson Laverne Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Moses-Sinclair 20 Gormlev Ave. Roosevelt, NY 11575 Aunt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State Pinelawn Mem. Cemetery May 27, 2011 Farmingdale, NY Donation 5 Other Specify 22. Name and Address of Facility. Burrier-Oueen Funeral Home & Crematory 1212 W. Old Liberty Road Sykesville, M 21. Signalure of Funeral Service PA 21784 denin Enter the disease, or complicatis, is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Alcohol, Socaine, and Heroin Intoxication iate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the burial - transit Physician/Medical UNPENDED AMENDED IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) for Yes 2 No 9 Unknown 9 Unknown the detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? icate has been signed by page 2 should be detach \$ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a Was an

Division of Vital Records, P.O. Box 68760,

this certificate has To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi

funeral director, Be

completely filled in by the

Certification:

Medical

one)

29b. Signature end title of certifier

prior to completion of cause of autopsy performed? death? 1 🗸 Yes Yes 2 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✓ Other: Scene 1 🗸 Yes 28a. Date of Injury FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Unknown FOUND: Natural 1 Yes 2 V No Pending May 14, 2011 1330 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) 19 Golden Eagle Court, Westminster, MD (Specify) Single Family Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 15, 2011

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD 32. Redistrar's Signature

and manner stated

State 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

Registrar

Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2011 **Physician** 1100 AM Stevenson 05 /Medical 4c. County of Death,
Buttmole 4b. City, Town, or Location of Death Fecility Name (If not institution, give street and number) Examiner cetensville Manor Nursing Ridceway If Under 1 Year Months Days If Under 24 Hrs Birthplece (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Decurity Number 7. Age (In yrs. last birthday) Funeral 1∰M 2□F Days Hours 79 Maryland 220-26-4668 June 10, Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health end Mentel Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b County 10a State other traumatic event, the Medical Examiner must be notified a 1 2 Yes 2 □ No Director Maryland Anne Arundel Severn 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 6 United States Items 23a 21144 8208 Consett Court Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ᠿ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 6 1 ☐ Yes 2 Ho **Black** Specify: Specify: 3 → Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Doctors n and Mantal Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) Community Hospital 6th Sanitary Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Mary C. Stewart William E. Stevenson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Son in Severn, Maryland 21144 Health item 27 i 8208 Consett Court Antonio Parker Sr. -20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20e. Method of Disposition Department of important: if its any injury or o June 6, 1 2 Burial 2 ☐ Cremetion 3 ☐ Removal from State Landover, Md. 4 ☐ Donetion 5 ☐ Other (Specify) Harmony 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Lice see 4001 Benning Road NE Washington, DC 20019 23a. Part1 Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) ener Examiner Due to (or as e consequence of): Examiner To the Hospital or Attending Physician: The law requiras that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding physician and completaly filled in by tha funeral director, paga 2 should be detached for use es the buriel-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy Protate Specific Auticu Possible Prostate TLIVOS ZENS 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 1 Attatural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier D19667 5/28/2011 Carrie 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Gle 200 mg ord 21061 Rit cière H 508 Howay 7310 31. Dete filed (Month) State JUN 0 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7, 201^Y1 Month June Nancy Garrett Sheriff Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Mt. Airy 4c, County of Death Frederick Kline Hospice House Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 F Days Hours Months 578-42-4132 79 APPTILDay 3 ar) 1932 Director Yrs. Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1222 Pinecrest Circle 20910 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Cecedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Russell H. Garrett Evelyn L. Crandell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code William H. Sheriff / Husband 1222 Pinecrest Circle, Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 20c. Location - City or Town, State June 13. 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State 2011 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc.
500 University Blvd., W., Silver Spring, 21. Signature of Funeral Service Licensee 23a. Part 1. Let the disease, or complications that consider the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Hyponatremia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Ducito (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last death certificate be executed Hypertension Due to (or as a consequence of): nding physician ause as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 9 Unknown the hed 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Hypercholesterolemia Completed nas page 2 performed Yes 2X N 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Ceath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 X Natural injury 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🔲 Homicide determined Medical 29a. Certifier

Box 68760 P.O. Records, Division of Vital Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu To the I

Approximate Interval Between Onset and Death 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗌 Yes 2 No Hospice 4 Nursing Home 5 Residence 6 Other (Specify 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. $^{29\text{d. Date signed (Month, Day, Year)}}$ June~7 , ~201129c. License number D56496 of person who completed cause of death (Item 23a) (Type, Print) Uma Polam, MD 10801 Lockwood Drive, Ste. 205, Silver Spring, Maryland 20901 **ORIGINAL**

3. Time of Death

DC

White

10d. Inside City Limits

1 🛛 Yes 2 🗌 No

6:20 A M

Registrar

State

(Check

only one 29b. Signatur

31. Date filed (Month, Day, Year

of certifie

JUN 08 2011

Physician. Medica **Examine Funeral Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 ď Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit Division of Vital Records, P.O. Box 68760

	For State		;	State of M	aryland	•				nd M	lental Hy	giene	0 1	1	105	13
	Registrar	-				Cei	rtificat	e of De	eath			Reg. No.	U I	i i	170	
	1. Decedent's Nam		e, Last)	R.		Smith					2. Date of Dea Month May	30 Day	201	Year	3. Time of	
	4a. Facility Name (i		aive etre			Silitui	_	Tour or l	eastion of	Dooth	мау			of Death	1:20	P M
	Magnoli			et and number)				Town, or L		Death					raca	1
	5. Social Security N		6. Sex	7. Ag	e (In yrs. las	st birthday)	If Unde		If Under 24		8. Date of Birt	h		e Geo 9. Birthp	lace (State or	Foreign
	249-26-27	710	1 🗆 !	M 2 X F	95	Yrs.	Months	Days	Hours	Min.	June 20	, Year) , 19	15	South	Carol	ina
.	Usual Residence o	f Decedent 10b. County			10- 01-	Town or Lo								L	0d. Inside Cit	a. Limita
	Md.	,													1X Yes	
	10e. Street and Nu		.G.		<u> </u>	anham	10f. Zig	Code				10a Citiza	en of V	Vhat Coun		
		ellwood	Δνει	ານອ			102.,	2070	16		- 1		.S.		uy.	
	11. Marital Status	22111000		. Was Decedent		13.	Was Dece	lent of Hist	anic Origin	n? (Spe	cify Yes or No-			e - Americ	an Indian,	
	1 Never Mar			Armed Forces?		l				Puerto I	Rican, etc.)			k, White, e	etc.	- 1
	3 Widowed			If Yes, Give Year or Dates.			1 🗌 Yes	2 (A) No	Specify:			S	pecify:	Bla	ick	
no di in	(Sp	15. Deceder ecify only highe	nt's Educa est <i>grad</i> e	ation co <i>mpleted)</i>			kind of wo	rk done du		of worki	ng	16b. Kin	d of Bu	usiness Inc	dustry	
	Elementary/Sec	conday (0-12)		College (1-4 or	5+)	lite. D	O NOT use	e retired) iemake	~				Dr	ivate		1
3	8th 17. Father's Name	(First, Middle, L	Last)				поп			's Name	e (First, Middle,	Maiden Su			<u> </u>	
2	Johnni	ie		R	obins	on			Fran	nces			Ha	rdy		
	19a, Informant's N	lame/Relations	hip <i>(Type</i> ,	Print)		19b. Maili	ng Address	(Street an	d Number	or Rura	l Route Numbe	r, City or To	own, S	tate, Zip C	Code)	
	Flora Fo		rando	daughter		7813	Dell	wood	Avenu	ıe,	Lanham,	Mar	yla	nd 2	20706	
	20a. Method of Dis		3 ☐ Re	moval from State		ace of Dispo metery, crei	osition (Nar matory or c	ne of other place)			Date	20c. Loc	ation -	City or To	wn, State	
	4 Donation	5 Other (S	Specify)		Mt.	Oliv			<i>-</i>		5–2011				D.C.	
	21. Signature of Fu	uneral Service I	icense	BIOrn	n Oal						ald Tay ane, Wh					
T	2 a Bart 1. Enter	the disease, or	complica	ations that cause	d the death								LIU	11157	Approximate	e
	Immediate Cause	(Final	only one o	ause on each lin	e. ath	PMO C	cin	27	11	10 Cl	rt di	CPO	0	0/	Interval Bet Onset and D	
	disease or conditi resulting in death)		₽ a.	Due to (or as			ca	0,0			, 011	0 00				
	Sequentially list of	onditions	b.													
	if any, leading to it cause. Enter Under	mmediate erlying		Due to (or as	a conseque	ence of):										Į
	Cause (Disease or that initiated even resulting in death)	ts	c.	Due to (or as	a conseque	ence of):	****									
	Tooling in acain,		L.		,											
			d.													
	IF FEMALE: 23b. Was deceden		230	. If yes, outcome	of pregnan	cy	☐ Ectopic					2	3d. Da	te of de live	ery	
	in the past 12	No No		4 Pregnant a			Other (s						Мо	onth	Day	rear
1	9 ∐ Unkno₩	n									T					
	Part II. Other sign	ificant condition	ons contr	ibuting to death I	out not resu	iting in the i	underlying	cause give	n in Part I.			obaccous Yes 2 □			ne cause of d	eath? / Unknown
											24a, Was	an	24b. 1	Were auto	psy findings a	available
									<u> </u>			rmed?		prior to co death? 1 □ Yes		ause of
	25. Was case refer	red to medical						26. Plac	e of Death	(Check	(only one)	2 🔀 No		i 🗀 res	2 123 INU	-
	examiner?	No No	Hos	spital: 1	ient 2 🗆 E	ER/Outpatie	nt 3 🗆 D	OA Other	4 🔀 Nur	sing Ho	me 5 Resid	dence 6[Oth	er (Specify)	
	27. Manner of Dea	th 5 🗌 Pendir	20	28a. Date of inju		28b. Time o injury	f 2	28c. Injury a			28d. Describe h					
	2 Accident	Investi	gation				М	1 🗆 Y	es 2 🗆 N		·					
	4 Homicide			28e. Place of Inj building, et	ury - At hor c. (Specify)		reet, factor	y, office			28f. Location (S City or Tox		Numb	er or Rurai	l Route Numb	per,
	29a. Certifier	1X Certifying	Physicia	n: To the best o	f my knowle	edge, death	occured at	the time,	date and p	lace, an	d due to the ca	use(s) and	mann	er as state	ed.	
	(Check	2 Medical E	kaminer	on the basis of e	examination	and/or inves	stigation, in	my opinion	, death occ	curred at	the time, date a	and place,	and du	e to the ca	use(s) and ma	nner stated.
	29b. Signature and	title of certifie	M) \				c. License		7, -		29d. Date	signe	d (Month,	Day, Year)	
	•		4			_		006	205	55		0/3	2	[[
	30. Name and add		DY	SON 2	death (Item	23a) (Type,	Print) -	8200	Good	Lu	ck Road	, Lar	, ihan	n, Ma	ryland	20706
	31. Date filed (Mor	UN 07	2011	3. Registr	ar's Signat	re ba	del				ck Road					
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State Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3 4:10 Α Helen Jackson Scott June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sykesville Carroll Copper Ridge 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 M 2X F Months Days Hours Min Director 216-46-9254 Huntington, IN 8/28/1907 Usual Residence of Decedent fshow 10a. State 10b. County 10d. Inside City Limits with the Maryland aţ 10c. City, Town or Location Director or 28a-f sh notified 1 X Yes 2 No MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o Funeral 20815 USA /202 Bybrook Lane . Page 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 2 🔼 No Completed by _ Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify 3

▼ Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher DC Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles E. Jackson Loie Dobson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7202 Bybrook Lane Chevy Chase, MD 20815 Nancy Scott / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 6/7/2011 Suitland, MD 22. Name and Address of Facility Joseph Gawler's Sons 21. Signature of Funeral Service Lice 30 Wisconsin Ave NW Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Vist only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the use as yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death be detached the ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy has performed certificate 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🛣 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural 5 \square Pending work? To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At Completed filled in by the fu after death. 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 M Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and fitle of certifie 29d. Date signed (Month, Day, Year) 10 Ob Name and address of person who completed cause of death (Item 23a) (Type, Print) e State Registrar's Sign

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Day Month Year BERTRAM STRAKER 9.30P M may Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Patrixent River Health and Lournal Prince 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign 1 M 2 🗆 F 93_{Yrs} Hours 120-26-1853 Director Panama Nov. 3. 1917 Usual Residence of Decedent 28a-f show 10a State 10b. County with the Maryland at Director 10c. City, Town or Location 10d. Inside City Limits notified DC N/A Washington 1 🌁 Yes 2 □ No 10f. Zip Code **20001** 10e. Street and Number ō apt, 10g. Citizen of What Country? must be i Funeral 1009 450 Massachusetts Avenue, NW United States items ? permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. African 3 ₩ Widowed 4 □ Divorced Completed American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Hilton Straker McCulsky Elvena 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0001 Dexter C. Straker / son 450 Massachusetts Ave., NW, apt.#1009, Wash DC 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🔀 Removal from State 6/5/2011 Evergreen Cemetery Brooklyn, NY 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McGuire Funeral Service, Inc. ré no 7400 Georgia Avenue, NW, Washington DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Assiration months eument Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. E. ter Uncertying Examine Due to (or as a consequence of): Cause (Disease or linjury ur.
After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 Pregnant 9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Alzhamer's dementic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🔀 No Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 🗷 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 X Natural 2 ☐ Accident 3 ☐ Suicide 5 Pending Investigation 1 🗆 Yes 2 🗆 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD 5 3411 2615 May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shesadri

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>011</u> Physician/ Month May 31 6:27 a M Severe Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death National Lutheran Home Rockville Montgomery 5. Social Security Number Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 6. Sex 8. Date of Birth Days Months Hours Jan. 6, 1 M 2 X F 87 Director 579-20-0566 Yrs. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Howard Dayton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5217 Kalmia Drive 21036 USA should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: and Mental Hygiene.
is marked other than "natural", 3 ☒ Widowed 4 ☐ Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Automotive Association Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ William Windsor Catherine Cora Irene White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a tant: If item 27 is Beverly J. McCleaf/Step-daughter 5217 Kalmia Drive, Dayton, MD 21036 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of H Date cemetery, crematory or other place Important: If 1 X Burial 2 Cremation 3 Removal from State June 2, injury o 4 ☐ Donation 5 ☐ Other (Specify) Fairfax Memorial Park Fairfax, VA 22. Name and Address of Facility Francis J. Collins F 500 University Blvd. 21. Signature of Funeral Service Licenser ns Funeral Home Inc. Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ALABYTHING disease or condition resulting in death) ARDIAL Medical Due to (or as a consequence of): Examiner oron my Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-thansit that the death certificate be executed DEMENTI that initiated events resulting in death) Last Due to (or as a consequence of): nding physician ause as the burial-Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live can all Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 📈 No for 5 Other (specify) Month Day ed by the a detached f P.O. signed I Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of nas autopsy death? 2 **V** No 2 🗆 No ☐ Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, and the funeral director. Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ည 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DDA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🔲 Yes Investigation Could not be 2 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 100051158 MAY 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MAY 2011 COPGE FFa 4:06 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3212 EDGEWOOD RD. MONTGOMERY KENSINGTON Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 D F Hours Min. MARCH 31,1918 **Director** NEW YORK Yrs. 119-01-8547 93 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD. MONTGOMERY KENSINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3212 EDGEWOOD RD. 20895 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 1941— 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 2 N e 19 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: Year or Dates. WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) COMPUTER ENGINEER FED. GOV'T. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MICHAEL JOHN SUFFAE PAULINE MULLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL G. SUFFAE/SON 12902 GOODHILL RD., SILVER SPRING, MD. 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 6-2-2011 RIVERDALE, MD. 21. Signature of Funeral Service Licenses CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 name lelt M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MALIGNANT NEOPLASM RECTOSIGMOID disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of) that the death certificate be executed resulting in death) Last Due to (or as a consequence of) burialphysician the burial Physician/Medical Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day signed by the a 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sign & completed filled in by the funeral director, page 2 should be Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' Yes 2 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Example 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) MD D63196 MAY 31, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATTHEW McANDREW, M.D. 1355 PICCARD DR., ROCKVILLE, MD. 20850

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JUN 0 2 2011

32: Registrar's Signature

		Baltimore, Ma
ospital or Attending Physician: The law requires that the death certificate be executed)h	permit. Pages 1 and 2 s
		Department of Health ar
	oie	Important: If item 27 Is
y filled in by the funeral director, page 2 should be detached for use as the buria with a significant of the significant of th	a i a	any Injury or other trau

			For State Registrar	State of Marylan		artment of He r <i>tificate of D</i>		ntal Hygie Reg.	2011	19519
5	5.53	*	Decedent's Name (First, Middle, Last	t)				Date of Death		3. Time of Death
9.	Physicia /Medic	_	Helen	M. Sheah	nin			Month June 1.	Day Year 2011	3:20p ^M
	Examin		4a. Facility Name (If not institution, give Sacred Heart	street and number)		4b. City, Town, or L	ocation of Death		4c. County of Deat	th
			5. Social Security Number 6. Sec		last hirthday)	Hyatts If Under 1 Year		Date of Birth		George's
12	Funeral Director			□ M 2 3 F 99	Yrs.	Months Days	Hours Min.	(Month, Day, Ye 2 / 19 / 1	ear) Co	ash.,DC
	put *		Usual Residence of Decedent 10a. State 10b. County	100 Cit	ty. Town or Lo	cation				10d. Inside City Limits
	Maryla f sho	lor	,	George's		sville				1 ☐ Yes 2X No
	r 28a-	irec	10e. Street and Number		117400	10f. Zip Code		10g.	Citizen of What Co	buntry?
	death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral Director	5805 Queens Cha	apel Road		207	782		USA	
	er dea Items ner m	nue	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Specify , Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, Whit	
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lan	ould be f Mental I arked of atic eve	To Be	Constantine Kia	itta			Mary Si		•	
Maryland	1 and 2 should be Health and Menta em 27 Is marked ther traumatic ev		19a. Informant's Name/Relationship (7	ype. Print)	19b. Maili	ng Address (Street ar	nd Number or Rural R	loute Number, C	ity or Town, State, a	Zip Code)
	1 and Health Im 27		Gregory Kiatta	-			Court Date		Md. 20	
nor	ages int of I		20a. Method of Disposition 1★ Burial 2 □ Cremation 3 □	nemoval politi state	_	nsition (Name of matory or other place			,	,
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Superal Service Licen			od Cem. Name and Address	6/07/		Wash.,D	
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	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Myocardi		farction	1			Onset and Death 1 wk
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		ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Cerenary Due to or as a cons	uence of).	ry disea	se			Yrs.
	recuted and	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· Hyperten	sion					Yrs.
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687	ificate g phys	edical		,d				•		
Вох	death certific attending p	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna		□Ectopic pregnancy			23d. Date of de	*
	ne death the atten hed for us	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of o		Other (specify)			Month	Day Year
P.0	w requires that the de been signed by the should be detached	, Ph	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying cause giver	n in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
Records,	quires n sign uld be	d by	_osteoporosis,	congestive	heart	failure		1 ☐ Yes	2 √ 2 No 3 □ P	robably 4 □Unknown
O O	aw rei is bee 2 shoi	plete	. ,	, , , , , , , , , , , , , , , , , , , ,				24a. Was an		utopsy findings available
E. B.	: The law cate has page 2 s	Som						autopsy performe 1∐ Yes 2 X	d? death?	completion of cause of s 2 \sum No
Vital	iclan Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:		Other	26. Place of Death (C	Check only one)		
0	Phys this ral dir	2 :	1 Yes 2 No	1 Inpatient 2 28a. Date of Injury	ER/Outpatie		4XI Nursing Home	5 Residence d. Describe how	e 6 Other (Spe	ecify)
ion	Attending r death. ector: After y the fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	f 28c. Injury Work M 1 ☐ Y	? es 2 □ No		,,	
Division or	r Atte ter des irecto i by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At he building, etc. (Special	ome, farm, st	reet, factory, office	28f	Location (Stree City or Town, S	et and Number or Fi State)	Bural Route Number,
Q	pital o urs aft eral Di	Cer	On Carrie 4 On Article Bl	To the least of the						
	To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A —completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 ★ Certifying Ph 2 ★ Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deal ation and/or ir	n occurred at the tim nvestigation, in my op	e, date and place, and pinion, death occurred	d due to the cause at the time, date	se(s) and manner a e and place, and du	is stated. le to the cause(s)
	To the within To the To	Me	29b. Signature and title of certifier)		29c. License	number	29d	. Date signed (Mon	
	Ţ			thei-		1)19	1609		June 2,	2011
			30. Name and address of person who			•				
			raman Tuj	i M.D. 1081	0 Dar	nestown	Rd Ga	ithers	burg, Md	20070
1	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature		100		3,110	20070

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 06/01/2011 MILDRED ROANA SEWELL 6:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hebrew Home of Greater Washington Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** VA Country) 1 □ M 2 🄀 F Months Days Hours 0871971916 Director 230-46-1606 94 Usual Residence of Decedent or 28a-f shov notified at shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code r items 23a or iner must be n ō 10g. Citizen of What Country? Funeral USA 20877 8100 Fallow Drive within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Me Ilcal Examiner rmed Forces? Black, White, etc. ò ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify. "natural", Completed 3 X Widowed 4 □ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4th Domestic Worker Home permit. Page 1 and 2 should be filed in Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pauline Basil James Marlowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Higginbotham/daughter 7525 Weatherby Drive, Derwood, MD 20855 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Ardent 06/03/11 Cremation Sv Hanover, MD . Signatur / f Funeral Service Licer Snowden Funeral Home 22. Name and Address of Facility 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or compl shock, or heart failure./List only one ns that caused the death se on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician Demento disease or condition Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate Examiner Dualto (or sels noneequance or) day, leading to immediate cause. Enter Underlying attending physician and for use as the burial-ransit To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No eral after death.

eral Director: After this certificate filled in by the funeral director, pag 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 1 Yes 2 No ၉ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a ledical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

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Fazli

31. Date filed (Month, Day, Year)
JUN 0 3 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

6121

2. Registrar's Signature

Montrose

D00648

Rockville

MD

6-1-2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For		S	State o	f Maryla	nd / Dep	artme	nt of H	ealth an	nd M	ental Hy	gien	60 N		10	521
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Physicia	n/	Decedent's Name (-	,								2. Date of Dea	D	ay oo	Year		e of Death
Medic	al	David	Lee		Sipe		_	1				May 3	0,	201	11	11:5	50 A. ^M
Examin	er	4a. Facility Name (if no 124 Kon)				ber)		4b. City		Location of D	Death			c. County Anne		do1	
Funeral	-	5. Social Security Nun		6. Sex		7. Age (In yrs	. last birthday)	If Unde	Loth er 1 Year	I Lall If Under 24	Hrs.	8. Date of Birl	th	T			e or Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fune				FI						/2011 ısch Fu		hian	 	T) A	
permit Depar Impor any in		De	exa 1	17 7	Tec	leces					кац La	isch fu ine, Ow	ing	s, MI	one, D 20	736	
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Physician/		Immediate Cause (Fir disease or condition		_			ocarlic	al li	rface	tron						Onset ar	nd Death
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical			L d											_		
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Atter er dea ector by the	Certificate:		6 Could n	ot be			home, farm, str	eet, factor	y, office		2	8f. Location (S			er or Rura	Route Nu	mber,
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To the Hospital or Attending Physician: The law requires that the dewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the ecompleted filled in by the funeral director, page 2 should be detached.	Medical						wledge, death										manner stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State

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only one)

29b. Signature and title of certifier

ddress of person who completed cause of death (Item 23a) (Type, Print)

384 3 1 3U1

M.D.

660 32. Regierar's Signature DO05 1735

Church Hill Road Chestertown.

29d. Date signed (Month, Day, Year)

5/26/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Ellsworth Schoenberger Mayonth 23 Day 201 far 4:24 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Carroll County Westminster Dove House Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth oct. 7, 213-34-1756 1 🔀 M 2 🗆 F 74 Months Hours **Director** 1936 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director Maryland Carroll County Hampstead 28a-f 1X Yes 2 ☐ No 10e Street and Number items 23a or ner must be n 10f. Zip Code 10a. Citizen of What Country? Funeral 4300 Buckskin Trail 21074 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1

Yes 2 □ No If Yes, Give 1955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. Specify: white "natural", 1955 Completed 3 Divorced Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 12 should be filed within 72 alth and Mental Hygiene.
27 is marked other than "I fraumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) bricklayer construction 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Ida Rhoades Joseph E. Schoenberger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Peggy E. Schoenberger/wife 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 24, Department of Important: If it any injury or conce. ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Hampstead, Maryland 2011 21. Signature of Funeral Service License 22. Name and Address of Facility Eline Funeral Home 934 South Main Street uns M01072 Hampstead, Maryland 21074 23a, Part 1, Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on ea Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Diverto (or as a consequences of) cause. Enter Underlying Cause (Disease or iinjury Exami sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month the Unknown P.O. þ signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes Yes 2 director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No 1 🗌 Yes DATITIX 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year, 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending Accident 🗌 Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifiei Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Pfactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I 29b. Signature 29d. Date signed (Month, Day, Year) WJL IDTIVA 30. Name and ddress of person who co eted cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year

HUENUE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Alexander Scenna 2011 2:35a May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fairhaven Healthcare Center Sykesville Carroll 8. Date of Birth (Month, Day, Year) April 27, Birthplace (State or Foreign Country)
PA Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 1 ☑ M 2 □ F Director 96 167-03-5281 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 X No MD Howard Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 20723 8213 Cool Creek Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. the Medical Examiner Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced WWII White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Art Design Commercial Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Vincenzo Scenna Maria Ferzoca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 8213 Cool Creek, Laurel, MD 20723 Mr. Ray Scenna (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 X Removal from State injuny Boca Raton Mausoleum 05/31/2011 4 □ Donation 5X□ Other (Specify) Entombment Boca Raton, FL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Hay PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or compiliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death rostate Physician/ disease or condition resulting in death) 120LIS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed the burial-transi Due to (or as a consequence of) attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: မ 1 Yes 2 200 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🗮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) D34849 WSL

State Registrar

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

1645 Libert

32. Registrar's Signature

Rd Eldersburg MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Williamian Mo

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle, Last. 2. Date of Death Physician/ Medical 2011 May 1:00pm M Bradford В. Schwab, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5805 Miriam Drive Sykesville Carrol1 If Under Social Security Number 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Age (In yrs. last birthday) Months Feb. 28 1948 Hours Min 1 X M 2 □ F 212-50-4894 63 MD **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Sykesville Carrol1 1 Yes 2 X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5805 Miriam Drive 21784 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 9 þ 1 Never Married 2 X Married 1 Yes : Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Specify. "natural", Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry should be filed within 72 m in and Mental Hygiene. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Photographer Photography Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bradford B. Schwab, Sr. Agnes Szymanski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Mrs. Paula Schwab (Spouse) 5805 Miriam Drive, Sykesville, MD 21784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State All County Cremation 4 Donation 5 Other (Specify) 6/2/2011 Sykesville, MD PO box 195 Sykesville, MD 21784 CHAPEL, PA 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 욘 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of Injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completed filled in by the fun 5 Pending iniury 2 Accident 2 No Investigation M 1 Yes 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Mman 1 29b. Sign 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print 9

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State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Death 2130 M Physician/ 101 >HOCKLE FREDERICK Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Edgewater 214 Spruce Avenue Anne Arundel 5. Social Security Number 8. Date of Birth (Month, Day, 19) 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Hours 1 ☑ M 2 □ F Louisiana 437-60-8328 1943Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No SC Pawleys Island Georgetown 10g. Citizen of What Country? by Funeral 29585 USA 299 Bannockburn Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give 3 🗌 Widowed 4 🔲 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Welder Welding vear Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lester Shockley Mary Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Shockley/ Wife Bannockburn Rd., Pawleys Island, SC 29585 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Kalas Crematory 5/31/11 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura Attack 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or immy) Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 2 No ate has been signed by the page 2 should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy a No 1 Yes 2 No Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital ESIDENCE 2 No ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of 29d, Date signed (Month, Day, Year) 21438 2011 74 0, Name and address of person who comple ed cause of death (Item 23a) (Type, Print APULLI MDLIKOI

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

gistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 29c per IVR 29d per med cert G9 Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charles Edward Sliger, Jr. 9:22 ам Medical 05 201 28 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Garrett 18 Center St. 0akland Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
MD 8. Date of Birth 1 **X** M 2 □ F (Month, Day, 02 01 Months Days Hours Min. Director 233-76-3034 1948 63 Usual Residence of Decedent ms 23a or 28a-f show must be notified at filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Garrett 0akland 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 18 Center St 21550 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or than "natural", or iter the Medical Examiner 14. Race - American Indian, Armed Forces' Black, White, etc δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 ☐ Yes 2 ☐ No 1967 If Yes, Give 1 🗌 Yes 2 🔀 No White Completed 3 Widowed 4 Divorced Specify. 1970 Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 8 Laborer Private or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Sliger, Sr. Reatha Maxine Shahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Jane Sliger-wife 18 Center St, Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Deer Park Cemetery 6/1/2011 Deer Park, MD 21. Signature of Puneral Service Licensee, 22. Name and Address of Facility David A. Burdock Funeral Home PA 21 N. 2nd ST, Oakland, MD 21550 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Small Physician/ Cell Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 🗌 No certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ known 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes Investigation 2 No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May 29, 2011 H26154 Vu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel Miller, 69 Wolf Acres Drive, Oakland, MD 21550 31. Date filed (Month, Day, Year) State Registrar's Signat JUN - 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 9:00 Quinter Royer Slaubaugh рм 2011 06 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Garrett 268 Spring Hill Circle Oakland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1**⊠**M 2□ F 94 232-01-3427 WV Director 27 1916 Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 0akland 1 ☐ Yes 2 X No Director MD Garrett 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 268 Spring Hill Circle 21550 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. White þ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) beauty barber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Buckalew Martha Ezra Slaubaugh ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3310 Sellman Road, Adelphia, MD 20783 Eugene Slaubaugh -son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/6/2011 Eglon, WV 4 ☐ Donation 5 ☐ Other (Specify) Eglon Cemetery 22. Name and Address of Facility David A. Burdock Funeral Home PA 0akland, MD 21550 Approximate Interval Between Onset and Death 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Physician/Medical Examiner Due to (or as a nonsequence of): if any, leading to immedie cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): the 98 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

or Attending Physician: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760, the attending physician has been certificate this within 24 hours after deatl To the Funeral Director: filled in by the

Hospital

should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

funeral director, page 2 should

1 Natural 5 Pending investigation

2 Accident Could not be determined 3 ☐ Suicide 4 Homicide

29a. Certifier

(Check only one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

1 ☐Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas G. Johnson, M.D., 311 North Fourth St, Suite II, Oakland, MD 21550

State Registrar

completely

Medical

31. Date filed (Month, Day, Year) JUN - 3 2011



11-04363 Abigail Moria Shu	Please Type or Print in Black Indel			le.
	1- For State Registrar Certific	ent of Health and Mental I ate of Death	Reg. No	
Physiciar Medical Examin	er Abigail Moria Shuey		2. Date of Death Month Day June 10, 2011	Year 0720 hrs
	4a. Facility Name (if not institution, give street and number) Meritus Medical Center	4b. City, Town, or Location of Dea Hagerstown		c. County of Death Washington
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last bir 220-89-0559 1 M 2 X F	thday) If Under 1 Year If Under 24H Months Days Hours M 25	→ `	9. Birthplace (State or Foreign Maryland Country)
land f show any once.	Usual Residence of Decedent 10a. State 10b. County Maryland Washington County Hagers	stown		10d. Inside City Limits 1 X Yes 2 No
with the Maryland a 23a or 28a-f show a Enotified at once.		10f. Zip Code 21742		tizen of What Country?
er death v	1 X Never Married 2 Married Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? () If Yes, specify Cuban, Mexican, Puerl	Specify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
36 nin 72 hours aft than "natural"	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind or during most of working life. DO NOT use re		Kind of Business/Industry
215-0036 be filed within 77 trial Hygiene. rked other than ent, the Medical	0	N/A		N/A
215-4 be filed antal Hyg riked oth	Phillip L. Shuey	Sabrin	e (First, Middle, Maider a L. Gladhi	ill Shuey
MD 21. nd 2 should be alth and Mer m 27 is mar	19a. Informant's Name/Relationship (Type, Print) Sabrina Shuey-mother 9	b. Mailing Address (Street and Number or 15 Mulberry Ave. Ha		
Baltimore, lemit. Pages I and Department of Heal Important: If tem Injury or other tra	20a. Method of Disposition 20b. Place of Cremation 3 Removal from State crematics	of Disposition (Name of cemetery, ory or other place)	Date 20c.	Location - City or Town, State nithsburg, Maryland
Balti permit. Departu Import injury	21. Signature of Funeral Service Licensee	22. Name and Address of Facility D 1331 Eastern Blvd	ouglas A. I	Fiery Funeral Home gerstown, MD 21742
Physician /Medical	23a. Part I. Enter the disease, pr complications that caused the death. Do not failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac		Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Sudden unexplaine Due to (or as a consequence of):	ed death in Infancy		Death
ner .	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
ansit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
O, be executed sician and ourial - transi		-f,per me,g917 7-8-1	l sm	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Puneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 9 Unknown	Fetal death 3 Ectopic pregn		d. Date of delivery Month Day Year
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for u		g in the underlying cause given in Part I.		use contribute to the cause of death? No 3 Propably 4 Unknown
Division of Vital Records, P.O. all or Attending Physician: The law requires that it as for death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaclarification: To Be Completed by E			24a. Was an	24b. Were autopsy findings available
Records, The law require. Figure has been signage 2 should be			autopsy performed?	prior to completion of cause of death? 1 Yes 2 No
Vital ysician: this certif	25. Was case referred to medical examiner?	26.Place of Death (Check utpatient 3 00A Other Nursi		ence 6 Other:
of Ning Phy	27 Manage of Double	Fime of Injury 28c. Injury at Work?	28d. Describe how in	
Sion Attendideath. death. cctor: by the f	Natural 5 Pending fd 6-10-11 fd	6:40 am 1 Yes 2 X No	Unknown	
Division o spital or Attending Jours after death. meral Director: After filled in by the fame. Certification:	3 Suicide 6 Could not be determined (Specify) Residen	rm, street, factory, office building, etc.	28f. Location (Street or Town, State) Hagerstown	and Number or Rural Route Number, City 915 Mulberry Ave.
Division of Vita To the Hospital or Attending Physicia within 24 hours after death. To the Funeral Director: After this co completely filled in by the funeral direct Medical Certification: To Be	Certifying Physician: To the best of my knowledge, dea one) 2 Medical Examiner: On the basis of examination and/or in and/manner stated.	nvestigation, in my opinion, death occurred	at the time, date and pl	ace, and due to the cause(s)
	29b. Signature and title of certifier	29c. License number O.C.M.E.		Date signed (Month, Day, Year) ne 11, 2011
GCME.	30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner	900 W. Baltimore Street, Balti	more, MD 21223	
State	31. Date filed (Month Day Year) 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 1626M rraine Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4th S Savett Daklano CHH Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 07-25-1922 Months Days Hours 1 - M 2 X F Director Maryland 214-12**-7**434 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Director 1 Yes 2 □ No Cumberland MD Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21502 U.S.A. 11506 Willow Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 1. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐Widowed 4 ☐ Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Ruth G. Miles Llovd Miles .. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4243 Ten Oaks RD Dayton, MD 21036 19a. Informant's Name/Relationship (Type, Print) Nephew Gary Kramer Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of h
Important: If its
any injury or of Cumberland, MD 06-14-2011 Cumberland Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home, P.A. M02547 40 Frostburg, MD 21532 60 W. Main St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Sers Physician/ disease or condition Medical resulting in death) Due to (or s a consequence of): **Examiner** 101 Sequentially list conditions, Due to for as a consequence of if any, loading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 month Live Birth 2 - Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ Veal Month Day Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 📉 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 2 Accident 5 Pending work 1 🗌 Yes 2 🗌 No Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 29d. Date signed (Month, Day, Year) 29b. Sign SM (Item 23a) (Type, Print) who completed cause of deat 30. Name and address of person 255 N. xa Kland Mr 4451 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D2011 J_{une}^{Month} 11, 6:35 p Jerome Schierzka Cyrus Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster Lookabout Manor If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Feb 2, 1915 1 ☎ M 2 🗆 F Months Hours MD **Director** 216-22-2832 Yrs 96 Usual Residence of Deceden shov the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 🗌 Yes 2 🔀 No MD Carroll Westminster ŏ 10e. Street and Number 10g. Citizen of What Country? or items 23a Funeral USA 2118 Tyrone Rd 21158 within 72 hours after death 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give Year or Dates. 1943 Black, White, etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1945 1 Yes 2 No Specify. than "natural", 3 Widowed 4 Divorced Specify Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. T. W. Cowan Diesel Mechanic 6 Be and 2 should be filed a Health and Mental Hyg 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Martha unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Shirley Schierzka/wife 2118 Tyrone Rd. Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 6/14/2011 Meadowridge Memorial: Elkridge, Maryland of Funeral Service Licen 22. Name and Address of Facilitts Funeral Home & Chapel, PA V_ 412 Washington Rd. Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events -tran and resulting in death) Last Due to (or as a consequence of) the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day signed by the at d be detached for Pregnant at time of death 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has page 2 autopsy perform death? Yes 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) <u>0</u> 1 Yes 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Spec Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work 1 🗌 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M f nd address of person who co

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month June 2, 11:30A 2011 Winifred В. Turner 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Anne Arundel South River Health&Rehab Center Edgewater | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Mar. | 28, 1920 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🗓 F 072-10-1291 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No Maryland Prince George Brandywine 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20613 15510 Baden Naylor Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Whalley Florence M. Arthur J. Brooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 201 Riverside Road, Edgewater, MD 21037 Patricia T. Pounds/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Baden, Maryland St. Paul's Church Cem. 6/6/2011 5 Other (Specify) 4 Donation 22. Name and Address of Facility George T. Kalas Funeral Home 21. Signatur Funeral Service Licentee 2973 Solomons Island Rd. Edgewater, MD 21037 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complica shock, or heart failure. List only one or complicat Therm coloratic Carolin Maccillas distence

Pnysician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

Funeral

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item 27 le marked other then "neturel", or Iteme 23e or 28e-f show other treumetic event, the Mark Sal Example of the collined at

permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Importent: If tem 27 is marked other then "neturel; or items 23e or 2, any injury or other treumetic event, the Mudical Example 200.0.

Baltimore, Maryland 21215-0036

the Maryland

Hospitel or Attending Phyelcien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.

filled in by

within 2 0

24 hours after death

	disease or condition resulting in death)	Due to (or as a consec	uence of):	c (diyel) o					
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Hypente Due to (or as a conseq	uence of):	arch'o vas	cular d	1/ ease			
dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a conseq d	uence of):						
Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknowh	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3 ☐ Ectopic	pregnancy (specify)		23d. Date of delivery Month Day Year			
by	Part II. Other significant conditions co		d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Munknown						
Completed	Dement	'C			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
0	25. Was case referred to medical			26. Place of De	ath (Check on one				
0 0	examiner? 1 ☐ Yes 2 🗹 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing I	sing Home 5 Residence 6 Other (Specify)				
ation: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28d. Describe how injury occurred					
ertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fac fy)	28f. Location (Street a City or Town, Stat	ocation (Street and Number or Rural Route Number, ity or Town, State)				
Medical Certification:	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurration and/or investigat	red at the time, date and plaction, in my opinion, death occ	e, and due to the cause(s urred at the time, date an	s) and manner as stated. d place, and due to the cause(s)			
Me	29b. Signature and title of certifier	c. Sw	20'no	29c. License number 5 0 6 5		ate signed (Month, Day, Year) $5 - 2 - 2011$			

GYAN C. SHRANA

Deale mid

20751

Registrar DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year,

ORIGINAL

christ

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deal &

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 MAY 31 Physician/ 3:14 A THOR TREIDER Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY BETHESDA NATIONAL NAVAL MEDICAL CENTER 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6, Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Country **Funeral** March 26, Days Hours 1 🛛 M 2 🗆 F 92 Director None Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 XYes 2 No Cily of Oslo Norway 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number Funeral Norway Héggelivn 34C 0375 0375 Oslo, Norway Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Director Shipping Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. မ Oscar Wilhelm Treider Thora 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Heggelivn 34C 0375 Oslo, Norway Kari Anne T. Paust/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Honefoss, Norway 4 ☐ Donation 5 ☐ Other (Specify) Vestre Adal uneral Service Ligensee MO1315 22. Name and Address of Facility DeVol Funeral Home N.W. Washington, DC 20007 2222 Wisconsin Ave., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MULTIORGAN SYSTEM FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the burlal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the page 2 should be detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Myocardial Infarction, Stroke, Kidney Failure, 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Liver failure autopsy has performed' death? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate | 1 ☐ Yes 2 🔀 No completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27, Manner of Death 28b. Time of 28d. Describe how injury occurred injury 5 Pending 1 Natural Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Descripting Projection. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D-0 0102202593 (VA) CENTER NATIONAL NAVAL MEDICAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

BUTTS

JUN 0 2 2011

31. Date filed (Month, Day, Year)

LT

MC

USN 32. Registrar's Signatur BETHESDA MD 20889-5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-04401 Loris Edward Todd State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day June 11, 2011 1242 hrs Medical Examiner Todd Loris Edward 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Chesapeake Beach 3934 James Lane If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Days Director Country) Maryland 09-06-1986 1 X M 2 F 215-13-9975 24 Usual Residence of Decedent 10d. Inside City Limits IN 10c. City. Town or Location 10a. State 10b. County 1 Yes 2 X No 28a-f show Chesapeake Beach Baltimore, MD 21215-0036
permit. Pages I and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Calvert Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20732 3934 James Lane Funeral 11, Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. must be r White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Yes 4 Divorced If Yes, Give Year Specify: White 3 Widowed Yes 2 X No specify: ۾ r Dates 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) roof truss plant construction worker Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ann Todd Loris Monroe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဂ္ 19a, Informant's Name/Relationship (Type, Print) 3934 James Lane, Chesapeake Beach, MD Mary Ann Lyons, mother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 06-17-2011 Waldorf, MD Trinity Mem. Gardens 4 Donation 5 Other Specify: 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee William 8325 Mt. Harmony Lane, Owings, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease a Methadone Intoxication *E*xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g9177-7-11 sm☐ UNPENDED attending physician for use as the burial the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death Year Live birth 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. é 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available After this certificate has been prior to completion of cause of autopsy performed? page 2 ✓ Yes 2 No 1 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical director, Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural Division 1 Yes 2 X No 5 Pending Director: fd 6-11-11 fd 12:20 pm 2 ___ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3934 James Lane Chesapeake Beach, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after To the Funeral Dire 3 Suicide 6 X Could not be determined (Specify) Residence 4 Homicide 29a. Certifier 1 Certifying Physicia. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examine . On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E June 12, 2011 30. Name and addr 💅 of person who completed cause of death (Item 23a)

W)OCWE

Deputy Chief Medical Examiner Mary G. Ripple MD. 31. Date filed (Month) 32. Registrar's Signature

900 W. Baltimore Street, Baltimore, MD 21223

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended#13 5/31/11 M.S. Kent Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death STER RIVER HOSPITAL HESTERTOWN 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Min. MARCH 17, Country) Director MD 77 213-32-4313 Usual Residence of Decedent or items 23a or 28a-f show lid be filed within 72 hours after death with the Maryland Mental Hygiene. 10b. County Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD **KENT** CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 304 CEDAR ST. 21620 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian Armed Forces?

1 XYes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. by Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 X Yes 2 X No Specify: "natural" Specify: WHITE 3 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 PHARMACIST PHARMACUTICALS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ VITO TINELLI, SR. MARY CARUSO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY TINELLI / WIFE 304 CEDAR ST. CHESTERTOWN, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State CHESTER CEMETERY 5/27/2011 CHESTERTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licens 21. Signature FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on Interval Between Onset and Death Immediate Cause (Final Physician/ ul mon ares disease or condition resulting in death) Medical e to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown g \ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ would 1 Yes 2 No 3 Probably 4 Dunknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗬 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

31 Date filed (Month)

15

completed cause of death (Item 23a) (Type, Print)

strar's Signature

Vn.

MD.

ARKABAZ

23889

High Street, CHertentown, ned 21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Alfred Milner Thompson Medical May 2011 2:00 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4011 Highfield Court <u> Hampstead</u> Carroll . Social Security Number If Under **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 🔀 M 2 🗆 F Months Hours Min **Director** Yrs. 217-26-6344 6/17/1931 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🎛 No MD Carroll Hampstead 10e Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral with 1 items 23a 4011 Highfield Court 21074 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, was beceden Ever in 0.5.
Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates.1952–54 Black, White, etc. 1 Never Married 2 Married þ "natural", or Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) construction carpenter Be permit. Page 1 and 2 should be filed uppartment of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edwin Warfield Thompson Alice V. Bull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva Marie Thompson, wife 4011 Highfield Court, Hampstead, MD 21074 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial 5/25/2011 Finksburg, MD M00741 22. Name and Address of Facility Eline Funeral Home Don 934 S. Main St., Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury) Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed lined in by the funeral director, page 2 should be detached for use as the burnal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? Yes 2 100 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Cther: 1 🗌 Yes 2 No |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature an 29d. Date signed (Month, Day, Year) WJL 6+1VA

State Registrar STREET LISETHIUSE IMPORTS

who completed cause of death (Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 26, Day 2011 Year Mav Month 4:00am M Robert Thomas Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll 2965 Ridge Road Westminster Social Security Number 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Funeral 1 🖫 M 2 🗆 F Months Days Min. Mar 7, 1931 Director 80 217-28-6881 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2965 Ridge Road 21157 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married þ 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 11 Truck Driver/Farmer Trucking/Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Thomas Turfle Judy Marie Barnes 19a. Informant's Name/Relationship (Type, Print)
Mrs. Dorothy Lee Turfle (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2965 Ridge Road Westminster, MD 21157 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Date cemetery, crematory or other 6/1/2011 Donation 5 Other (Specify) Tavlorsville UMC Cem. Taylorsville, MD 21. Signature of Funeral Service Licensée 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one came or each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death Yes 2 □ No ed by the a g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h performe 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1/ Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3. Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined To the Hospital within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Plactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westkinster, MD 21157 Flavio Kruber HD SSS South Couler Street

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

Box 68760

Records,

Division of Vital

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	For			St	ate of M	arylar	nd / Department of Health and Ment	al Hygier	ne.	1	P. Contract
1-	State	Ammend	#1	Per	Phys.	WSH	6/1 <i>Odrtificate of Death</i>	Reg.	No.		

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Modical Evanting must be notified at any injury or other traumatic event, I'm Modical Evanting must be notified at any once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

an cal		miena w							leg. No.					
cal	1. Decedent's Name	First, Middle		m m				2. Date of Dea Month	th Day	Year	3. Time of Death			
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er	4a. Facility Name (I	f not institution	n, give street and number	")		4b. City, Town, or Location of Death			4c. County of Death					
	Manor Ca	re				Catonsvi	11e		Baltimore					
	5. Social Security N	umber		ge (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h /,_Year)	Cou	Birthplace (State or Foreign Country)			
	212-90-46		12M 2□F	40	Yrs.	Yrs. Months Days Hours Min. 7/3/1970 Country)								
	Usual Residence of 10a. State	Decedent 10b. County		10c City	, Town or Lo	ration				1.	I Od. Inside City Limits			
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ect	MD 10e. Street and Nun	Baltin	more	Ranc	lallsto	10f. Zip Code			10a Citiza	en of What Cou	ntry?			
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Funeral Director			12. Was Deceden	t Ever in LLS	13 \	Vas Decedent of H	isnanic Origin? (S	necify Yes or No-	14	I. Race - Ameri	can Indian.			
ᇤ	11. Marital Status Never Marri	ied 2 Marr	Armed Forces	?		Yes, specify Cuba				Black, White,				
β	3 ☐ Widowed	_	If Yes, Give Year or Dates			□Yes XX No	Specify:		S	Specify: Wh	ite			
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Š	Elementary/Seco N/A		55115g5 (1 45)	01,	Di	sabled				N/A				
Be (17. Father's Name	(First, Middle,	Last)					ne (First, Middle,	Maiden S	urname)				
2	Unknown						Riva Tr	aub						
	19a. Informant's Na					g Address (Street								
	Riva Trau	b - Mot	her			Foxcliff								
	20a. Method of Disp		3 ☐ Removal from Stat	20b. P	lace of Dispo emetery, cren	sition (Name of natory or other plac		Date		ation - City or T				
	4 □ Donation			Res	surect	ion Acres	5/23/2	2011	Balt	imore,	MD			
	21. Signature of Fu	neral Service	Licenses	<u> </u>	22 R11	. Name and Addre	ss of Facility	al Home	and	Cremato	rv. P.A.			
	Burrier-Queen Funeral Home and Crematory, P.A. 1212 W. Old Liberty Rd. Winfield, MD 21784													
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between													
	Immediate Cause (Final disease or condition a. ESOPHAGEAL CARCINOMA													
	resulting in death) a. Due to (or as a consequence of):													
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_	23b. Was decedent in the past 12			2 Feta	death 3	Ectopic pregnanc		23d. Date of delivery Month- Day Year						
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Physicia	9 🗆 Unknown	1	9 🗆 Unknowr		ulting in the u	nderlying cause aix	en in Part I.	23e. Did t	obacco us	se contribute to	the cause of death?			
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To Be Completed by Physicia	9 Unknown Part II. Other signif 25. Was case referexaminer? 1 Yes 2	ficant condition	9 Unknown	but not resu	ER/Outpatier	nt 3□ DOA Ott	26. Place of Deler: 4 Xursing h	24a. Was auto performe 5 Resi	an psylonger (a) an psylonger (a) an psylonger (b) and a psylonger	No 3 Pro	obably 4 □ Unknown topsy findings available ompletion of cause of 2 □ No			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 4:05A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett Garrett County Memorial Hospital Oakland 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth **Funeral** 1 □ M 2 🏿 F Months 3/18/1919 218-82-8227 Director 92 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2X No Friendsville MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21531 778 Square Fike RD. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 ☐ Yes 2X No If Yes, Give Year or Dates Specify White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Fearer Teets Pearl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1122 Campground RD., Addison, PA 15411 Emogene BArefoot/ Daughter Baltimore, Important: If item any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of 1 Strial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6/6/2011 Friendsville, MD Asher Glade Cem. 22. Name and Address of Facility Newman Funeral Homes P.A. Signature of Funeral Service License Grantsville, MD 21536 179 Miller St., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the burial-transi that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 use as yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months
1 Yes 2 No Month Other (specify) Pregnant at time of death signed by the at 1 be detached fo P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at work?
1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Muse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year, 30. Name and address of person who cor of death (Item 23a) (Type, Print) State

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vivari June 1, Physician/ Barbara Ames 201^y1 10:40 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Brighton Gardens If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 1/10008 av 1/923 579-20-7855 87 **Director** Vashington, DC Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director Rockville MD Montgomery 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a or ner must be n Funeral United States 20850 12605 St James Road death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 0 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🔽 No Specify: Specify: White "natural", 3 Widowed 4 K Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Psychiatric Social Worker Social Work Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental F 27 is marked of traumatic even permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked on any injury or other traumatic everones. ည Mary Olive Norman Bruce Ames 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12605 St. James Rd, Rockville, MD 20850 Bruce Vivari/Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Heaven Cem 6-3-2011 Silver Spring, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons Inc. Will 5130 Wisconsin Ave. NW Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physician/ End Stage Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypertensive Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 ding parts as t IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fetopic pregnancy in the past 12 months? ö Month Year 5 Other (specify) Day Pregnant at time of death 4 ☐ Pregnant been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an sate has l page 2 s autopsy performed? Yes 2 XNo certificate To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 💢 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Living within 24 hours after death.

To the Funeral Director: After this

Eqmpleted filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -27660 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alpana Goswami MD 11125 Rockville Pike Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 6 2011 Registrar

11-04081 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Etny Torres Ventura State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea, No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month **Medical Examiner** 2040 hrs May 31, 2011 ETNY TORRES VENTURA 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Chester River Hospital Chestertown 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Months Days Hours Director 1 X M 2 F PUERTO RICO 04/15/1975 584-37-1511 36 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location iny Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 X No KENT MILLINGTON Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UNITED STATES 10687 GALENA ROAD 2165 uneral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 2 X No Yes 屲 4 Divorced If Yes, Give Year or Dates: 1 X Yes 2 No specify: PUERTO RICAN | Specify: PUERTO RICAN 3 Widowed ě 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 INVENTORY TAGGER NURSERY 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) å **EDWARDO TORRES** BENITA VENTURA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10687 GALENA ROAD MILLINGTON, MARYLAND 21651 JAMIE VENTURA / BROTHER 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 06/07/2011 PUERTO RICO 4 Donation 5 Other Specify MUNICIPAL VILALBA 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME,
370 W. CYPRESS STREET MILLINGTON, MD 21651 21. Signature of Euneral Service Licen Approximate Interval Part I. Enter the disease, or compli ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical a Cardiac Arrhythmia Complications of Gastrointestinal tract infection Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit x AMENDED 23a,27,per me,g925 3-8-12 sm attending physician a for use as the burial -UNPENDED Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Year Live birth Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown certificate has been signed by the att rector, page 2 should be detached for Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 Other: Inpatient 2 V ER/Outpatient 3 this 1 🗸 Yes ဥ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28d. Describe how injury occurred 1 🗹 Natural death. 1 Yes 2 No 5 Pending with n 24 hours after death To toe Funeral Director: the Certificati 2 ___ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined 4 Homicide 29a. Certifier 1 completely Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. gistrar's Signatu

Trithall, My 30. Name and a res f person who completed cause of death (Item 23a)

Pamela E. Southall, MD

31. Date filed (Month; Day, Year)

State Registrar

Rm

O.C.M.E.

June 1, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 04 2011 06 10:20A Helen Psomas Vlamis Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital E1kton Cecil 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Hours (Month, Day, Year) 04/04/1918 93 Director 216-18-6737 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 XYes 2 No Ceci1 E1kton 10e. Street and Number 23a or 10f, Zip Code 10g. Citizen of What Country? by Funeral 801 Bridge Street 21921 USA should be filed within 72 hours after death and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner Operator / Restaurant Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Psomas Mathilda Coroneos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Nicholas Vlamis / son 801 Bridge Street, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/11/2011 Elkton, MD Aviat Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 259 East Main Street, Elkton, MD 21921 art 1. Enter the drease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart in lure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events tu for as a consequence of resulting in death) Last attending physician a for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months? 1 Yes 2 No 3 Ectopic pregnancy Month Pregnant at time of death Day Year 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccq use contribute to the cause of death? Completed by Records, 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page Hospital or Attending Physician: The 1 🗌 Yes 2 🗆 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🔏 မ Appatient 2 ER/Outpatient 3 DOA After this Certificate: Manner of De th Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 24 hours after death. Funeral Director; Al 1 ☐ Yes 2 ☐ No Accident Investigation the 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HOWARD L. VESS 10° JÜNE 2011 9:49A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 15496 OLD MARSHALL HALL RD. ACCOKEEK PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** Days 1**X** M 2 □ F Months Hours 579-22-3493 Director 89 FEB. VIRĞINIA Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location Director 1 🗆 Yes 2 🔀 No GEORGE'S MD PR. ACCOKEEK 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 15496 OLD MARSHALL HALL ROAD 20607 U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates W. W. II 1 ☐ Yes 2XXNo Specify: Specify: WHITE 3XXWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5 + Elementary/Seconday (0-12) SCIENTIFIC ENGINEER NAVAL RESEARCH LAB Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ OLA VESS CATHRYN COUTTS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20646 19a. Informant's Name/Relationship (Type, Print) ROBERT V. PRICE, JR. / FRIEND 128 HAWTHORNE GREENE CIRCLE LA PLATA, MD 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State 4 Donation 5 Other (Specify) ARLINGTON NAT.CEM UNK ARLINGTON, VA 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 Signature of Funeral Service Licensee and 1 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Day Month page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 🗌 Yes 2 🗌 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural injury work 5 Pending 2 🗌 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check et the time Cartifying Nurse Practionan To the best of my or ly one! 29b. Signature and title 010

State Registrar 30. Name and address

31. Date filed (Month, Day, Year)

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ SONJA 0518 WINGFIELD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min DEC. 21 ^{Year)} 951 WASHINGTON, DC **Director** 579-68-3438 Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PRINCE GEORGE'S **BLADENSBURG** 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 5802 ANNAPOLIS ROAD 20710 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 K No Specify. BLACK Specify: 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 and Mental Hygiene.
7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) STAFF ASSISTANT 12th GOVERNMENT permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည AUBREY V. WATERS VIRGINIA GILLISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIRGINIA WINGFIELD/DGT 5802 ANNAPOLIS ROAD BLADENSBURG, MARYLAND 20710 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗶 Burial 2 □ Cremation 3 □ Removal from State emetery, crematory or other place) CHELTENHAM, MARYLAND MD VETERANS CEME. 6/9/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Enter the ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Approximate Interval Between neart faily Immediate Cause (File) whethou Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events that the death certificate be executed -tran and resulting in death) Last burialphysician s the burial Physician/Medical Box 68760 nding L IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown P.O. Other significant contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No Other: 1 Yes မ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No the f Investigation after deati Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical ny knov 1 Certifying Physician: To the best of 2 Medical Examiner: Of the basis of a 29a. Certifier yedge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

on and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check 3 🗆 within 2 To the 1 Certifying Nur ath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 65367 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

HOSPITAL

3001

SATTARIAN

DR MEHDI
31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Rear INF G921 11/09/2011 THealth and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 9:08AM DAVID EDWARD WILLIAMS 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Doctor's Hospital Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security N5867 **Funeral** 7. Age (In yrs. last birthday) Country) NY Hours 1 1 1 2 3 4 1 Min. 1 🕅 M 2 🗆 F 69 095-34-5887 Director Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 X Yes 2 No "natural", or items 23a or 28a-f MD Prince George's Forestville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20747 USA 7318 Donnell Place, Apt. 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Completed by should be filed within 72 hours after Black Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical sonce. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Consultant Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hannah Lance Alfred P. Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 19a. Informant's Name/Relationship (Type, Print) 7318 Donnell Pl., Apt. D3, Forestville, MD Margaret Williams/wife Baltimore, 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 05 - 31 - 2011Cedar Hill Cem. Suitland, MD 4 Donation 5 Other (Specify) 20746 22. Name and Address of Facility 21. Signature Uneral Service Licenses Cedar Hill FH,4111 PA Ave., Suitland, MD 232. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No is certificate has been signed by the director, page 2 should be detached 1 Urknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed After this certificate 1 ☐ Yes 2 ☐ No Yes 2 L Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 X ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation Director: 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c, License number 25/11 D64268 and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Good Luck Road, Lanham, Royce A. Burns 31. Date filed (Month, Day, Year) State UN 0 6 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per fh g920 10-7-11 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 201 Claudia Caulfield West June 11:45 A^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City Town, or Location of Death 4c. County of Death 3637 Edelmar Terrace Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛛 F Months Days Hours Min. (Month, Day, Director 226-76-9168 1947 Washington, DC 63 Dec. Usual Residence of Decedent shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No Maryland | Montgomery Silver Spring 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 3637 Edelmar Terrace 20906 United States items and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc ò ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 'natural" 3 Widowed 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Preschool Teacher Preschool Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ other traumatic Samuel Joseph Caulfield Louise Olive MacLean McLean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i Bryan F. West, Spouse 3637 Edelmar Terrace, Silver Spring, Maryland 20906 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State Department of F Important: If ite any injury or ot once. Page 1 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Parklawn Memorial Park 06/09/2011 Rockville, Maryland permit. 21. Signature of Funeral Service-Licensee 22. Name and Address of Facility Simple Tribute MO1102 ROLL 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ metastatic carcinoma of the ovary disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examir and Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical certificate be Box 68760 as attending IF FEMALE: JSe 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ō in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 1 Yes 240 the par Unknown Division of Vital Records, P.O. sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 **X** No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral Certificate: 28d. Describe how injury occurred 1 X Natural iniurv 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0055522 June 6, 2011 uar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert H. Gerard, 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month Registrar's Signatu

State

Registrar

JUN 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#26cerMD, 6/7/11, BW, MCCO state Registra AMEND#19boerFH, 6/7/11; BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Woldermareyam June 2011 10:41 p^M Medical 4a. Facility Name (if not institution, give street and number) 7881 Briardale Terrace **Examiner** 4b. City. Town, or Location of Death County of Death
Montgomery Derwood 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 1 🗌 M 2 🔀 F Days Hours **Director** 96 none Eritrea Apr. Usual Residence of Decedent 10a State notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f Fairfax Springfield 1X Yes 2 No 10e Street and Number ò 10f. Zip Code 10g, Citizen of What Country? be Funeral ıral", or items 23a Examiner must b 8232 Woodstown Court 22315 Eritrea 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No Specify: Black "natural", Specify: Completed 3 X Widowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) Self-Employed College (1-4 or 5+) Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important; If item 27 is marked o any injury or other traumatic eve ဂ Tsegaye Woldemariam Amleset Woldekidan . ailing ddress (S reet and Num er or rai Rou um er, ity or own, State, 19a Informant's Name/Relationship (Type, Print)
Almaz W. Tsehay (Daughter) Bacon 14th S Home , Funeral 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 06/11/2011 Asmara, Eritrea Family Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licence 22. Name and Address of Facility
W. H. Bacon Funeral Home, Inc.
3447 14th Street, N.W. Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to car as a dunsequence of cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) ıding physician Physician/Medical P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy
5 Other (specify) ō in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Gangrene 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 K No certificate 1 🗌 Yes 2 🔀 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital daughter's residence Other: ြို 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pendina work?
1 Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 7 o Cu ss of person who completed cause of death (Item 23a) (Type, Print) Rockville 1355 Piccard . Coleman 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year May 26, 2011 Physician/ 5:19 P M Watts Margaret Amv . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday **Funeral** (Month, Day, Ye April 23 Days Hours 1 M 2 F Months Guatemala 579-18-2730 Director 96 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State with the Maryland Director Chevy Chase 1 Yes 2 No Md. Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20815 #602W 4620 North Park Avenue · death \ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 XNo Black White, etc. 1 X Never Married 2 Married Š Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify White Specify. If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) the U.S. Dept. of State Administrative Assistant permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, ဂ Dolores Diaz-Duran Joseph Henry Watts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4620 N.Park Ave. #602W, Chevy Chase, Md. 20815 C. Henry Watts/Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cem. June 1,2011 Silver Spring, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenese MO131 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W., Washington, DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Left middle cerebral artery Stroke Physician/ disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner Atrial fibrillation Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Que to for se a consecutiona chi Urinary tract infection Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) attending physiciar Physician/Medical C. difficile colitis To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day detached for 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 3 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> decreased left ventricle function, sepsis, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an myocardial infarction autopsy page 2 MU performed? death? Yes 2X No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be 90 examiner? Hospital Other: 1 🗌 Yes 2 🔀 No 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 27. Manner of Death Certificate: 2 injury 5 Pending Natural after death. Accident
Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 🗌 Homicide determined City or Town, State) 0 within 24 hours a

To the Funeral I

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 7165312 126/11 8 26

Registrar

DHMH 17 Rev 7/2009

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State

31. Date filed (Month, Day, Year

JUN 0 1 2011

Sugarshan Siva, M.D., 8600 Old Georgetown Road, Bethesda, Md. 20814

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 29 ^{Day} 2011 Physician/ 12:00 Newton Wixon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Dayton Glen Hill Assisted Living 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthy OK **Funeral** 6. Sex 1 🗆 M 2 🕱 F Months Days Hours Min. (Month, Day, Year) **Director** 500-14-1225 90 Dec. Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland must be notified at Director 1 Yes 2 K No Silver Spring MD Montgomery 10f. Zip Code 5 10e, Street and Number 10g, Citizen of What Country? items 23a Funeral **IISA** 20906 2904 N. Leisure World Blvd. death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc. ō 1 Never Married 2 Married þ filed within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No SpecifiWhite "natural", 3 Midowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fay Stokes Mark Newton Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10701 Marietta Street, Glenn Dale, MD 20769 Henry N. Wixon/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town, State Date Department of B Important: If ite any injury or ot cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State June 3, 2011 Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD permit, F 21. Signature of Furieral Service Licensee 22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc.
500 University Blvd.W., Silver Spring,MD 20901 Approximate Interval Between Onset and Death I week Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Respiratory Failure resulting in death) Medical Due to (or as a consequence of): Examiner since 12/05 Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transity. since 12/05 Cerebral Hemorrhage that initiated events Due to (or as a consequence of) resulting in death) Last since 12/05 Physician/Medical Seizure Disorder Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 2 9 Unknown Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X☐ No 3 ☐ Probably 4 ☐ Unknown Completed Breast Cancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 ☐ Yes 2 🔣 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be ASSISTED LIVING

4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at XX Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Cify or Town, State) Medical 29a. Certifier 1 Xeertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3

State Registrar

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JUN 0 6 2011 DHMH 17 Rev 7/2009

29b. Signature and title of certif

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dana S. Simpler. MD 808 South Conklin Street, Baltimore, MD 21224

29c. License number

D35170

29d. Date signed (Month, Day, Year)

June 2, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 06 Year **Physician** 9:15am Elizabeth Williams 01 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hyattsville Prince George 926 Karlson Ave If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthdav 5. Social Security Number 6 Sev Funeral Days 1 □ M 2 C F 88 04/26/23 South Carolina 113-18-9764 Director Usual Residence of Decedent Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiprry or other traumatic event, it is Modical Examiner must be notified at any pinc. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1XX Yes 2 ☐ No Director Md Hyattsville Prince George 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 926 Karlson Ave 20783 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: Black \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Government Mail Handler 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Benjamin Williams <u>Daisy Washington</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Philistine Williams Niece 926 Karlson Ave Hyattsville, Md 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Riverdale Crematory 06/02/11 Riverdale, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Snead Funeral Home & Cremation 0777 5732 Georgia Ave NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arcinomA Physician holangio disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 I Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐No 1 □Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Be aminer examiner? 1**½** Yes 2 ∏.No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Atter i 1 Natural 5 Pending 1 ∐Yes 2 ∐No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:

completely filled in by the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0031173 6-1-201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nelson, MD., FACC 6525 Belcrest Rd Hyattsville, Maryland 20 Rayman K. I State

DHMH 17 Rev 1/2001

Registrar

JUN 0 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1955 State of Maryland / Department of Health and Mental Hygiene? RegistraMEND#10f+19perINF,6/6/11; BWW,Mcco Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 30, 2011 Physician/ 5:30 pm Nathaniel Weil Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Spring House If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Numbe **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign (Mopth, Pay Year) 9 1 X M 2 □ F Months Days Hours Min. itry) New York Director 91 097-12-6046 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 ☐ Yes 2 🗓 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20910 Funeral 2201 Colston Drive, #400 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 X Widowed 4 Divorced 1950 Caucasian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Distribution Warehouse Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Julius Weil Estelle Bernstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Humber or Rural Route Number, City or Town, State, Zip 1901) 0 2026 Twin Road, Silver Spring, MD 20001 Gary Weil - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lebanon Cemetery | 06/01/2011 | Adelphi, Maryland 21. Signat 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
I Year Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) After this certificate has been signed by the attending physician and After this certificate, should be detached for use as the burial trace. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit. that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 ves, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy

Consert at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Coronary Artery Disease 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 K No death? Anemia 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Assisted Other: 4 \square Nursing Home 5 \square Residence 6 $\underign \underign$ Other (Specify) 2 🛛 No 1 Inpatient 2 ER/Outpatient 3 DOA Living 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated The cause of the c 29b. Signature pro title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D28656 May 31, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi, M.D., 15245 Shady Grove Road, #130, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) State JUN 0 2 **201**1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Robert Beyer Webber РМ 29 2011 8:50 May Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Genesis Eldercare-Layhill Center Silver Spring 8. Date of Birth (Month, Day, Year) June 7, 1928 Birthplace (State or Foreign Country)
 KS Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Months Hours Min. 1 🛛 M 2 🗆 F 509-22-6949 82 Yrs Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Silver Spring MD Montgomery 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 3210 North Leisure World Blvd. #412 20906 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates. WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16h. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked မ Edward James Webber Elizabeth Beyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 5614 JOrdan Blvd., New Market, MD 21774 Robert Buerkle Webber/Son other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury or June 2, 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, MD Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Lice 500 University Blvd. W., Silver Spring, MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Failure disease or condition Rena1 Medical resulting in death) Due to (or as a consequence of) Examiner Debility Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) an and The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FFMALE 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav 5 Other (specify) Pregnant at time of death 1 Yes 2 g Unknown ned by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA hin 24 hours after death.

the Funeral Director: After this

mpleted filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 🛚 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical/Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 3 Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. raptioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

complet 3 only one) 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) May 31, 2011 D64208 M. 10

State Registrar

Box 68760

P.O.

31. Date filed (Month, Day, Year)

JUN 0 3 2011 DHMH 17 Rev 7/2009

30. Name and address of person whe

Saadia Husein, MD

arked

3227 Bel Pre Road, Silver Spring, Md 20906

pleted cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u>Thomas</u> Mav 1:30 Edelen Webb Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Calvert Chesapeake Beach 6335 15th Street 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Hours Min 08-30-1943 1 X M 2 □ F Virginia **Director** 218-42-2371 67 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1

Yes 2 □ No MD Chesapeake Beach Calvert 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 6335 15th Street 20732 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after death 12. Was Decedent Ever in U.S. 14. Race - American Indian 1. Marital Status Armed Forces? Black, White, etc. ō ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than "ury or other traumatic event, the Mec Elementary/Seconday (0-12) College (1-4 or 5+) 10 Truck Driver Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Hamilton Webb Attawa Edelen Middleton Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6335 15th Street, Chesapeake Beach, MD Jacqueline L. Webb, spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State injury o 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 06-03-2011 Dunkirk, MD Signature of Funeral Service Licensee Rausch Funeral Home, 22. Name and Address of Facility any ir 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) ed by the a a I Inknown g 🗍 Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 💆 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: A Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) D16823 who completed cause death (Item 23a) (Type, Print) Robert Schlager, M.D., 8924 Chesapeake Avenue, North Beach, MD 31. Date filed (Month, Day, Year) 32. Registra s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Wilson Physician/ Mil Year 0130 AM Bemice 6 Medical 4a. Facility Name (if not institution, give street and number)
Ches tertoun Nursing & Rehab 4c. County of Death 4b. City, Town, or Location of Death Examiner hestestown Kent If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Months 89 Director 215-26-4927 /15/192 MÉ Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Queen Anne's Chestertown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2215 Pondtown Road Funeral 21620 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ğ 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black If Yes, Give Completed 3 □Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT_use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Manufacturing Laborer 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Sparks William Bessie Rochester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elouise Deaton/Daughter 2215 Pondtown RD Chestertown, MD 21620 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 XBurial 2 Cremation 3 Removal from State Pleasant U M 6/11/2011 Chestertown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Bennie Smith Funeral Home 855 High ST Chestertown, MD 21620 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final CONGESTIVE Physician HEART FAILURE 10 year disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Il any, leading to immedicause. Enter Underlying Cause (Disease or linjury Quality for es e nonsequende of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? KIDNEY CHRONIC DISCASE 2 No 1 Tes 3 Probably 4 Unknown Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No DEMENTIA 24a, Was an page 2 autopsy performed? Yes 2 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 X No Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28c. Injury at work? 1 ☐ Yes Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending hours after death. 2 🗌 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours a Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signat ure and title of certifie 29d. Date signed (Month. Day, Year) 2 11 0 Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 mg PERENDINA MID ZIGZO 32. Regi State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ James M. Wells, Sr. 10:<u>52A</u> [™] 201: Mav Medical Ac. County of Death Anne Arundel 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Edgewater 318 Bay View Drive 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, 17, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Hours 1 X M 2 🗆 215-68-9830 56 Director May Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes XX No Edgewater Maryland Anne Arundel 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral USA 21037 318 Bay View Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 USA 1 ☐ Yes 2 💹 No If Yes, Give Year or Dates Specify 3√Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) American Tank Owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Rita Divver Horace P. Wells 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 519 Highland Drive, Edgewater, Md. Lindsay Kidwell/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗆 Burial 2 ื Cremation 3 🗆 Removal from State Edgewater, Md. 21037 Kalas Crematory 6/4/11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of 2973 Solomons Island Road, Edgewater, Md. Approximate
Interval Between
Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a continuence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No Yes 2 No funeral director. 25 Was case referred to medical 26 Place of Death (Check only one Be examiner? Other: 2 X No 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ၉ After this 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: Natural 5 Pending s after death.

I Director: Aft
d in by the fur Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de

To the Funeral Directo

completed filled in by the 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature 0010 Name and address of person who complete State

Registrar

Registrar

State

MEDICAL CENTER

DRIVE

ROCKVILLE

MARYLAND

SMITH

MD

9901

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jimmy Lampadio 4:07 PM Medical June 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Laurel Kegional Hospita Prince George's aure If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth 1 ₹ M 2 □ F Months 733-10-1813 49 FEB:47,1962 Philippines **Director** Yrs Usual Residence of Decedent 28a-f show iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Laurel 10d. Inside City Limits Director Maryland Prince George's 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code og. Citizen of What Country? **Phili**pp**ine**S Funeral 20708 13014 Old Stage Coach Road, #3117 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 \square Never Married 2 \square Married Baltimore, Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2X No Specify. "natural", 3 X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Lab Technician Laboratory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. ၉ Julian y_{11} Lilia Lampadio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13014 Old Stage Coach Road, #3117 Laurel, MD Tiffany Yu -daughter 20708 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metropolitan Crematory 6/8/2011 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licenses Bonald WireBorg Wardt Funeral Home, PA Do al 4400 Powder Mĭll Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between immediate Cause (Final Phy i ian Onset and Death Seizure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events Examine Due to (or as a consequence of) nding physical use as the burial-thansit To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and a be detached for use as the burial-than Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Dav Pregnant at time of death Year g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cardiomyopath Completed 1 Yes 2 No 3 Probably 4 Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 🕱 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🗶 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) upleted filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number Medical Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0057275 June 6, 30. Name and address of person who completed duse of death (Item 23a) (Type, Print) 7350 Van Dusen Rd., Suite 130 MD Rosenstock 20707 31. Date filed (Month, Day, Year) State JUN 09 Registrar

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

SHA

JUN 0 3 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RO AD

ROUKNILLE

MD 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ZIMET 5:30 A. M Violet June 8, 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death **Bethesda** 4c. County of Death Suburban Hospital Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month Day, Year) 1915 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** 9. Birthplace (State or Foreign 1 - M 2 V F 96 Director 055-16-4959 Vrs New York, NY 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Chevy Chase Director 10d. Inside City Limits MD Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20815 7106 Lenhart Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Dolinsky Oscar Barengoltz 19a. Informant's Name/Relationship (Type, Print) 19106 Lenhart Dr., Chevy Chase, MD 20815 /daughter Beryl Zbar Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Levil Frace of Disposition (Name of conference of Pate 12/2011 | emple Beth Shaffold Cen 06/12/2011 1 ▼ Burial 2 □ Cremation 3 ▼ Removal from State 4 □ Donation 5 □ Other (Specify) Sarasota, FL 22. Name and Address of Facility | Torchinsky Hebrew Funeral Home Washington, DC 20012 254 Carroll St., NW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Cardiomypathy disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Cause (Disease or linjury that initiated events resulting in death) Last Pneumonia Due to (or as a consequence of):
Advanced Alzheimer's Disease Physician/Medical 687 IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death 5 Other (specify) be detached 9 I Inknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Alzheimer's Disease Records, 1 ☐ Yes 2 ☐XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 💢 No 1 Yes 2 No Hospital or Attending Physician: funeral director. 25. Was case referred to medical **Division of Vital** Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Hospital Other: 1 Inpatient 2X ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work?
1 Yes 2 No within 24 hours after death

To the Funeral Director: /
completed filled in by the f Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of c 29c License number 29d. Date signed (Month, Day, Year) 25 7011 ted cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Rd., Bethesda, MD 20814 31. Date filed (Month, Day, Year State JUN 0 9 201

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:30A M UNR Medical 4a. Facility Name (if not institution, give stieet and number) Town, or Location of Death **Examiner** 4c. County of Death SON touse 1 COT owar Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8 Date of Birth Month Pay, Year Days Hours 59-76-018 M 2 □ F Months Director Usual Residence of Decedent or 28a-f show 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits **Funeral Director** must be notified 0 Howard ic. 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 3920 SON Rogo No 01 items and 2 should be filed within 72 hours after death v Health and Mental Hygiene. tem 27 is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced ASIAN Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medica an Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ a 19a. Informant's Name/Relationship (Type/Print) 19b. Mailing Address (Street and Number or Rural Route Number, Road Department of Health Important: If item 27 any injury or other tr hsan OUS 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, prematory or other place) Date 20c. Location Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Olumbia Momrial Signature of Funeral Service Licensee - curcina Howe 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Stage Liver Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-transi Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year g Unknown Division of Vital Records, P.O. signed by t 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed iis certificate has been si director, page 2 should i 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes 2 X No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 🗶 No Be 26. Place of Death (Check only one) Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify, After this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 Tyes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifi è 29d. Date signed (Month, Day, Year) Dp\$67273 June 14 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6350 Stevens Forest Rd., Ste. 102, Columbia, Maryland 21046 Deepak A. Shah State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ iUne 201 Medical Examiner Town, or Location of Death 4c. County of Death ledica timare 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min Month, Day, Country) Director 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 3-9 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 2 Yes 2 No Way
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Transpa Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) q 364/ Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City of Town, State Date unk 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 21. Signature Fineral Service 22. Name and Address of Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest, shock, or heart failure. List only one cause on e. ch lin. Approximate Interval Between Ons t an Leath Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (o as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir -transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical that the death certificate be P.O. Box 68760 attending IF FEMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for in the past 12 months? Day Month Pregnant at time of death Unknown 2 No the detached g Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 To the Hospital or Attending Physician; The law requires Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed page 2 should . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? the Funeral Director: After this certificate In pleted filled in by the funeral director, page Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospita 2 💢 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred 1
Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No r death. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined after City or Town, State) within 24 hours a

To the Funeral D Medical 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 29b. Signature

JUN 20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5:55 PM Bannister contro Medical 4c. County of Death Examiner Baltimore varies If Under 24 Hr Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 M 2 WF 100 Director or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director M.Dtimore 1 ¥ Yes 2 ☐ No 10g. Citizen of What Country? or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes : 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry ecify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Be ည tilend Methed of Disposition Place of Disposition (Name of ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 25-2011 4 Donation 5 Other (Specify) 21. Signat, re of Fune al Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease of impury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): nding physician ause as the burial-Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown jo 4 Pregnant at time of death
9 Unknown Day Month Year ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown Diabetes Hellitai . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? this certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Natural work? 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 11006426 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State JUN 20 Registrar

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	Physicia		Fannie	- (,	*	Elizabe	th	Barne	ett	Month	Day		3. Time of Death
	Medic Examin			not institution, gi	ive street and number)			4b. City, Town, or Lo	ocation of Death	1.06	16	2011 County of Deat	5:45a. M
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	Funeral		5. Social Security N	umber 6.		ge (In yrs. last	, ,		f Under 24 Hrs. Hours Min.	8. Date of Bir	th v Year)	9. Bir	thplace (State or Foreign untry)
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	and show	tor	10a. State	10b. County		10c. City, To	own or Loc	ation					10d. Inside City Limits
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	th wit	iner		orth El	lamont S			212				U.S.A	A •
(0	r dea or iter niner		11. Marital Status1 Never Marri	ied 2 Married	12. Was Decedent Armed Forces	?	13. W	as Decedent of Hispa Yes, specify Cuban, I	anic Origin? (Spe Mexican, Puerto	cify Yes or No- Rican, etc.)		 Race - Ame Black, White 	
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Maryland 21215-0036	should be and Ment is marked aumatic e		19a. Informant's Na				19h Mailin				r City or	Town State 7in	Codolo 3 o 3 c
	and 2 Health em 27 her tr				Daughter			Address (Street and North El	llamont	Stre	et,	Balti	more, Md
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot		20a. Method of Disp 1 Burial 2		Removal from State	e cem	etery, crem	ition (Name of atory or other place)		Date		cation - City or	
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- Jo	ng Ph fter th ineral		27. Manner of Death	5 Pending	28a. Date of inju	ury 281	b. Time of injury	28c. Injury at work?		28d. Describe h			11) b 100 p 1 de
ion	tendi leath. :or: A: the fu	i£ica 	Accident 3 Suicide	Investigati	ion			M 1 ☐ Yes	2 □ No				
ナ舟ハハ・C. Division of Vital		Certificate:	4 Homicide	determine	28e. Place of Inj	ury - At home, c. (Specify)	, farm, stre	et, factory, office		28f. Location (S City or Tow		Number or Rui	ral Route Number,
	Hospit 4 hour unera ed fille	Medical	29a. Certifier 1 (Check 2	Certifying Ph	nysician: To the best of	f my knowledg	je, death o	ccured at the time, da	te and place, an	d due to the ca	use(s) and	manner as sta	ited. cause(s) and manner stated.
5	thin 2 the I		only one) 3	Certifying Nu	urse Practioner: To the	best of my kn	owledge, de	eath occurred at the tin	ne, date and plac	e, and due to th	e cause(s)	and manner as	stated.
	P ≥ 60		29b. Signature and t	and certifier	/ _			29c. License nu	mber		29d. Date	e signed (Month	n, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** TEPHEN PM 2130 0 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 820 S. CONKLING STREET BALTIMORE 8. Date of Birth (Month, Day, Year) DEC. 31, 1934 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days MARYLAND 219-30-8849 76 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notifiled at Yes 2 No Director N/A MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 820 S. CONKLING STREET 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 2 Yes 2 □ No If Yes, Give Year or Dates: 1955-56 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify. Specify: WHITE ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If them 27 is marked other the any Injury or other traumants. ELECTRICIAN GENERAL MOTORS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be STEPHEN COLLISON BEARD, SR. RUTH C. CUNNINGHAM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL BEARD/ WIFE 820 S. CONKLING STREET, BALTIMORE, MD 21224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD CEMETERY 6/25/11 4 Donation 5 Other (Specify) BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 100'S. & CONKLING STREET, BALTO., MB 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA /Medical Due to (or as a consequence of). 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Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

JENNIFER HAYASHI 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5505 HOPKINS BAYVIEW CIRCLE BALTO., MD

32. Registrar's Signature

11-04467 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Latonya Cox 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day June 14, 2011 **Medical Examiner** 0245 hrs Cox ATOMUA 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Raltimore Johns Hopkins Hospital 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Months Days Hours Director 15-86-2596 45 1 M 2 X F Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location in 1 Yes 2 No or items 23a or 28a-f show must be notified at once, AltimoRE MARYland death with the Maryland Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 5 Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 No ICAN AMERICAN permit. Pages I and 2 should be filed within 72 hours after teppertment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", of injury or other traumatic event, the Medical Examiner m If Yes, Give Yeer or Dates: 3 Widowed 4 Divorced 1 Yes 2 No specify: é 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 TH 18. Mother's Name (First, Middle, Father's Name (First, Middle, DORIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11)ARillAnd 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 1 Burial 2 Cremation 3 Removal from State June 16 2001 Altimore. 4 Donation 5 Other Specify: 22. Name and Address of Facility
Ancy m. Withnee Fyneral Service 2/1279
3405 W. Franklin Street Baltimore Mary Mar ature of Funeral Service Licenses elage t. Entain the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart Lis only one cause on each line. Atherosclerotic Cardiovascular Disease complicated Approximate Interval **Physician** Between Onset and /Medical a by mixed Narcotic use Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Records, P.O. Box 68760,
The law requires that the death certificate be executed Due to (or as a consequence of): attending physician and for use as the burial - tran Physician/Medical AMENDED 23a, 27, per me, g917 7-1-11 sm X UNPENDED Division of Vital Records, P.O. Box 68760, IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Volknown Completed as been s 2 should 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? page , ✓ Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) director, Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other After this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 1 X Natural 1 Yes 2 No 5 Pending the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) within 24 hours a To the Funeral I determined 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

State Registrar

Medical

29b. Signature and title of certifier

Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registra/s Signature

30. Name and address of person who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year)

June 14, 2011

and manner stated

11-04393 Henry K. Chung Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 9566

iciliy it. Ollulig		1- For State Certificate of Death		Z U I I Reg. No.	1730
Physicia	in/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of De		3. Time of Death
Medical Exami	ner	Henry K. Chung	June 11,	2011	1020 hrs
		4a. Facility Name (if not institution, give street and number) Atlantic General Hospital 4b. City, Town, or Local Berlin	ation of Death	4c. County of Death Worcester	
Funeral			Under 24Hrs. 8. Date of E	Birth(MM/DD/YYYY) 9. Birth	thplace (State or
Director		212-06-6345 1 DM 2 F 59 Yrs. Months Days 1	Hours Min. May	Foreig	
any .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	اڃا	MD A.A. Glen Bur	nie		1 Yes 2 No
Aaryland 28a-f shnw at once.	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Cour	ntry?
th the Maryland 23a or 28a-f shu	₫	1017 Phillip Drive 2101	01	USA	
15-0036 filed within 72 hours after death with the Maryland I Hygiene. d'atther than "natural", or items 23a or 28a-f sh i, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispani If Yes, specify Cuban, Me.		Io- 14. Race - Ameri White, etc.	can Indian, Black,
er dea		1 Yes 2 No 3 Widowed 4 Divorced of Yes, Give Year 1 Yes 2 No sp	ooife:	Specify: A	Bian
hours aft "natural" Examine	ğ	15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (16b. Kind of Business/I	
72 ho	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	NOT use retired)	Residen	tial
5-0036 led within 72 Hygiene. Inther than the Medical	Completed	12 Sub-Contro	ctor	Developr	next
21215-0036 Juld be filed within 7 Mental Hygiene. marked nither than te event, the Medica			other's Name (First, Middle	, Maiden Surname)	20
2121 uld be fi Mental J marked	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and	Number or Rural Route Nu	umber, City or Town, State	Zip Code)
AD 2 sho 1 and 27 is mati		Abigail Chung (Daughter) 1017 Phillip	Dr. Gler		MD 21061
re, M 1 and 2 7 Health fitem 2 er traum	ľ	20a. Method of Disposition 20b. Place of Disposition (Name of cemeter crematory or other place) Removal from State	y, Date	20c. Location - City or	Town, State
imore Pages 1 nent of F		4 Donation 5 Other Specify: Glen Haven Memor	al 6/16/20	11 Glen Bu	rrue, MD
Baltimore, permit. Pages 1 as Department of He Impurtant: If ite	Ì	21. Signature of Funeral Service Licensee 22. Name and Address of F	acility Howell	Funera	& Home
	_	23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such	Hora Ka,	Jessup,	Approximate Interval
Physician //Medical	-	failure. List only one cause on each line.	as calculac of respiratory a	riest, snock, or rieart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as e consequence of):			
		Sequentially list conditions, b			
	ine	if any, leading to immediate cause. Enter Underlying Cause			
T	Examiner	events resulting in death) Last Due to (or as a consequence of):			
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit		d.			<u> </u>
60, ate be ex hysiciar e burial	Medical	UNPENDED		1	
876 tificat ng ph; as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ed	ctopic pregnancy	23d. Date of delivery Month	y Day Year
Box 687 c death certific. the attending p ed for use as th	Sick	4 Pregnant at time of death 5 Other (Specify)			
O. Bo it the de	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I 23e. Did	tobacco use contribute to	the cause of death?
ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed teath. tor: After this certificate has been signed by the attending physician and rithe funeral director, page 2 should be detached for use as the burial - trans	à	Control of the contro			ably 4 Unknown
cords,	Completed		24a. Was		topsy findings available
e law e has ge 2 sh	E E		auto	ormed? death?	ompletion of cause of
Vital Rec ysician: The Discertificate director, page		25. Was case referred to medical 26.Place of D	eath (Check only one)	2 No 1 Ye	s 2 No
Vita hysicia this ce	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA	4 Nursing Home 5	Residence 6 Other	:
ling Ph	١	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at (Mopth, Day, Year) 28b. Time of Injury 28c. Injury at (Mopth, Day, Year)	— Subject dre	how injury occurred	
SiOn retend death. ctor: y the f	jặ	2 ✓ Accident Investigation Jun 11, 2011 0930 hrs	2 No		
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined (Specify) Ocean	or Town,	(Street and Number or Ru State) by & 1/4 mile from shore	101
Tospita t hour		29a. Certifier 4 Continue Physicial To the heat of my knowledge, death accurred at the time date of	_ I		
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: /	Medical	one) 2 Medical Examined: On the basis of examination and/or investigation, in my opinion, dea and manner stated.			
F & F S	ŝ	29b. Signature and title of certifier 29c. License nur	mber	29d. Date signed (Mor	nth, Day, Year)
FED's		O.C.M.E.		June 12, 2011	
GEME	t	30. Name and address of person who completed cause of death (Item 23a)	and Delking 14D C	4000	
		Mary G. Ryople MD. Deputy Chief Medical Examiner 900 W. Baltimore Str	eet, Baitimore, MD 2	1223	
Sta	ate	31. Date filed (Month, Day Year) 32. Registry's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year CARRINGTON GNES 1101 011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death D BALT RANDALLST Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth Funeral 1 M 2 F Hours Director Usual Residence of Dece or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Himore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 IJSA tarlem Wenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Completed 3 ₩idowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) To Be 19b. Mailing Address (Stree 20b. Place of Disposition (Name of Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Six a re of Fune al Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or initiary that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year signed by the and be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed Yes 2 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 AP/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOOTHWELL NOSPITAL FABER, 31. Date filed (Month

DHMH 17 Rev 7/2009

Registrar

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Frances Elizabeth Corun Jun 14, 2011 Year 10:50 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Ellicott City** 3617 Chatham Rd. Howard 5. Social Security Number **Funeral** . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 💢 F Months Hours Min. (Month, Day, Year) Dec 19, 1928 216.24.9171 82 Director MD Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Completed by Funeral Director MD Howard **Ellicott City** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 3617 Chatham Rd. 21042 U.S.A. ?7 is marked other than "natural", or items traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No 3 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry iould be filed within 72 to marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Howard Co. Govt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Malinski Anastasia Lubunyz and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3617 Chatham Rd. Ellicott City, MD 21042 Albert F. Corun Spouse permit. Page 1 and 2
Department of Health
Important: If item 27
any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Meadowridge Memorial Park, Jun 18, 2011 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility ome, P.A. Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Part Foler the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ERTENSION Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ending physician and use as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ☐ Yes 2 N 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{Yes} \) 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No neral Director: A filled in by the f 2 Accident
3 Suicide Investigation Could not be 3 ☐ Suicice 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ellicottaty 025

DHMH 17 Rev 7/2009

State

Registrar

20

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State of Maryland / Department of Health and Mental Hygiene

			_ State	aryland / Depa <i>Cer</i>	artment of He tificate of De		,	211		19569
	Dhusisis	/	1. Decedent's Name (First, Middle, Last)		unouto or p		2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia Medic	al	Kichard Dameron 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L	anation of Dooth	06	13 2	011	11:15 A M
	Examin		University of Marylo	and	Ba Him		>	4c. County	oi Death	
	Funeral Director			(In yrs. last birthday) 37 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Nov. 11	1973	9. Birthpla Countr Silver	ace (State or Foreign ry) Spring, MD
	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10	d. Inside City Limits
	Maryla 28a-f s otified	Director	MD Harford	Aber	deen					1 Yes 2 XNo
	ith the	ralD	10e. Street and Number 378 Stratford Avenue		10f. Zip Code 2100	1		10g. Citizen of W		
	leath w	Funeral	11. Marital Status 12. Was Decedent E	ver in U.S. 13.	Vas Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Spe		14. Race	e - America	n Indian,
036	of flied within 72 hours after death with the Maryland the Hygiene. It al Hygiene. Other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 🗶 Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.	No	Yes 2X No		i nodii, oto.)		k, White, et Whit	
2-0	°2 hour "natul edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupat kind of work done du	tion ring most of worki	ng	16b. Kind of Bu		
212	within ? giene. er than , the M		Elementary/Seconday (0-12) College (1-4 or 5-	+)	o NOT use retired) ice Advi	sor		Janes T	'oyot	a
and	be filed within 72 hours after death with the Maryland hend Hygiene, and Hygiene, and charter than "natural", or items 23a or 28a-f sho cevent, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) Richard Vern Dameron, S	Sr.		18. Mother's Name Barba	e (First, Middle, I)	
Maryland 21215-0036	2 should be file lith and Mental H 27 is marked o r traumatic eve		19a. Informant's Name/Relationship (Type, Print) Melynda Dameron - Wife		ng Address (Street an Stratfor					
re, l	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	!	Date	20c. Location -		
Baltimore,	t. Page tment c tant: If jury or		1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Chapel-	uneral Bel Air	- $+$ $ +$ $ +$		Forest		
Ba	permir Depar Impor any in		21. Signature of Funeral Service Licensee		Name and Address Vans Fun 800 Harf	of Facility neral Cl ord Rd	napel & C Parkvil	remation le, MD 2	1234	viœs
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.				r respiratory arre	est,		Approximate Interval Between Onset and Death
	h sician/ Medical	1	dise se or condition resulting in death) a. Due to (or as a	ceal Hern consequence of: Not Dep	norrhas	e				nknown
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_	certificate be executed inding physician and use as the burial-transit	edical Ex	resulting in death) Last Due to (or as a	consequence of):						
9/8	ificate l ng phys as the		IF FEMALE:	-						
89 x09	death cert he attendir ed for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	2 🗌 Fetal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Dat Mor	e of deliver	ry Day Year
Ö.	the dea	hysid	1 Yes 2 No 4 Pregnant at 9 Unknown 9 Unknown	time of death 3 C						
s, P.O.	law requires that the death certific ras been signed by the attending I s 2 should be detached for use as	d by F	Part II. Other significant conditions contributing to death but	ut not resulting in the u	nderlying cause give	n in Part I.				e cause of death? ably 4 X Unknown
örd	w requi s been 2 shouk	Completed by			_		24a. Was a autop	ın 24b. V	Vere autops	sy findings available inpletion of cause of
Ř	: The la cate ha						perfor	med? d	leath?	
/ital	/sician s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	ent 2 ER/Outpatier	100	e of Death (Check		ence 6 🗆 Othe	or (Specify)	
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 to		27. Manner of Death 1 Natural 5 Pending (Month, Day,	y 28b. Time of	28c. Injury a work?	at		ow injury occurre		
ISIO	Attend or death octor: / by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury	ry - At home, farm, stre		es 2 □ No		treet and Numbe	er or Rural I	Route Number,
N	oital or urs afte ral Dire		building, etc.				City or Tow			
	re Hosp 24 ho re Fune pleted fi	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of responsible to the best of the	amination and/or invest	tigation, in my opinion	, death occurred at	the time, date ar	nd place, and due	to the caus	se(s) and manner stated.
	Vithii To th	_	29b. Signature and title of certifier		29c. License r		:	29d. Date signed	(Month, D	lay, Year)
	0		30. Name and address of person who completed cause of de	eath (Item 23a) (Type, F		237		06/1.	5/11	
			Rebecca Krochmal 2	22 South	n Green	e Str	ee+	Baltir	nore	MD 21211
	Stat Registra		31. Date filed (Month, Day, Year) 32 Registra	r's Signature	Kel					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De Month Physician/ Day Year Blake P. Deweese 336 pm 06 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Baltimore Franklin Square Hospital Center Kosedale If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
WVA 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 5. Social Security Number 236-22-7133 (Month, Day, 1 March1 1**X** M 2 □ F 87 Yrs Director 1924 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Middle River 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral $17\frac{1}{2}$ North Hawthorne Road 21220 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Completed by 1 Never Married 2 Married X Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 XNo Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Worker Beth Steel 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည French Deweese Dessie McLaughlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Davis /daughter 1405 Beetree Court Belair MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🙀 Cremation 3 🗆 Removal from State Bayview Crematory 6/15/11 4 Donation 5 Other (Specify) Baltimore MD 22. Name and Address of Facility 21. Signature of Fu eral Service Licensee 300 Mace Ave. Balto. MD Funeral Home of Essex 23a. Part V. Enter the disease, or co shock, or heart failure. List only implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each one. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic Obstructive disease or condition a Severe Medical resulting in death) Due to (or as a consequence of) Examiner Seque tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and the burial-tran Due to (or as a consequence of): resulting in death) Last cate has been signed by the attending physician page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year

Pregnant at time of death 5 Other (specify) 9 Unknown

Month Day

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of

24a. Was an autopsy perform Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

28b. Time of

MD

death? 2 No 1 Yes

4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury 1 X Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be

2 No

injury work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination through the course of the firm, of the firm, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

determined

29c. License number D0061662

Other:

28c. Injury at

29d. Date signed (Month, Day, Year) 2011 06/14/

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 Franklin Square Drive, Baltimore MD, MD Dr. Johnathan Hansen

State Registrar

To the Hospital of within 24 hours a To the Funeral D

101

Completed by

Be

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Certificate:

Medical

29a. Certifier

Deweese, Blake

31. Date filed (Month, Day, Year) **JUN 2 0 2011** 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 16° 201T 11:30P M С. Deaver Laura Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A Lyndale Avenue Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) Days March 31, 1923 1 M 2 X F 88 New Jersev 155-07-0789 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21213 USA 3731 Lyndale Avenue 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc δ 1 Never Married 2 X Married 1 Yes : 2 X No Baltimore, Maryland 21215-0036 Specify: White 1 Tes 2 No Specify. Completed 3 🗆 Widowed 4 🗆 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) File Clerk Insurance Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Samuel Romeo Clara Boya 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3731 Lyndale Avenue Baltimore Maryland 21213 Frederick H. Deaver/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Moreland Mem. Park 6/20/11 Baltimore Maryland 21. Signature of Funeral Service Licenses 22. Name and Address Ruck, Inc. 01 5305 Harford Road Baltimore Maryland 21214 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trans physician and Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No signed by the atte Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 🗆 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2/2/No 욘 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Aff
d in by the fur 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours aff

To the Funeral Di

completed filled in Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Signatu and title of 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

ARIG 31. Date filed (Month, Day, Kidac

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHMOUD

32. Registrar's Signature

MD

Westminst

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dorothy S. Fravel 13 June 2011 5:30 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson **Blakehurst** Baltimore Social Security Number last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs April 17 1 🗆 M 2 🗶 F 87 Hours 214-22-2733 Director Virginia Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director Baltimore Towson 1 ☐ Yes 2 🏝 No MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 1055 W. Joppa Rd. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: If Yes, Give Year or Dates Specify:White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Andrew Shaver McLelland Kate permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic o other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3702 Meadowhill Ct. Phoenix, MD. 21131 19a. Informant's Name/Relationship (Type, Print) Carey Henning/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🛚 Burial 2 🗆 Cremation 3 🗀 Removal from State Druid Ridge Cem. Pikesville, MD. 6-20-11 4 Donation 5 Other (Specify) 21. Signature of Fymeral Service Licens 22. NaRe and Address of Facility Funeral Home, 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Examiner Squentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has 1 Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (heck only one) Be examiner? 2 TNo 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA rsing Home 5 🗌 Residence 6 🗌 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending Accident Investigation within 24 hours after death To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certif N Charles Freet Ballimore My 4204 se of death (101 670

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 0 2011

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June June Donald Flynn 2011 11:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oak Crest Care Center Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 80 Months Hours Min ALIQUST Z New York °1°930 086-22-2007 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8834 Walther Blvd. Apt. CC322 21234 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify White Specify: Completed 3 Nidowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the 1 once. Manager Western Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Daniel Flynn Coyne Anne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Landon / Daughter P.O. Box 43894 Nottingham, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Dulaney Valley Mer Cher Name) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/21/2011 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitRuck Towson Funeral Home, Inc. 21. Signature of Funeral 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition resulting in death) WOSEPSUS Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): executed and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CKO IV. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe 2 🗌 No FUNN DO 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 18/2011 mpleted cause of death (Item 23a) (Type, Print) USON 8860 Wolfher Blud, Packville MO 21234 State

Registrar

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14NO

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			State of Maryland				-		Legible.	
	_	for State Registrar	State of Maryland		tificate of L			Reg. No.	011	19574
Physicia Medic		1. Decedent's Name (First, Middle, Last, Barbara H. Fi	came				2. Date of Dea Month June	ith Day	2 0 1 1	3. Time of Death
Examin		4a. Facility Name (if not institution, give s Manor Care /				Location of Death		4c.	County of Death	
Francis		5. Social Security Number 6. Sec	Rossville	hirthdayl	Ross If Under 1 Year	Ville If Under 24 Hrs.	8. Date of Birth			imore
Funeral Director			M 2 🔀 88	Yrs.	Months Days	Hours Min.	OCCC 3	O ^{Year} 9	9.22 Cour	place (State or Foreign htry) MD
/aryland 8a-f show tified at	rector	10a. State MD 10b. County Balti	more 10c. City, To	own or Lo						10d. Inside City Limits 1 ☐ Yes 2 🄀 No
with the N s 23a or 2 ust be no	Funeral Director	10e. Street and Number 10 Eugene Aven	ue		10f. Zip Code 21	221		10g. Citi:	zen of What Cou	ntry?
, or	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	'	Nas Decedent of Hi f Yes, specify Cuba	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Americ Black, White, Specify: Wh	
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Page 1 a ment of H ant; If ite ury or otl		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,	Removal from State	e of Dispo etery, cren Law	sition (Name of natory or other plac 'n Cemet	ery 6/2	Date 0 / 1 1		cation - City or To altimor	
permit. Depart Import any inj		21. Signature of Funeral Service Ucensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221								
Physician/		23a. Part 1/ Enter the disease, o com shock, or heart failure. List Immediate Cause (Final disease or condition	ications that caused the wath. Decause on each line.		er the mode of dying	g, such as cardiac c	or respiratory arre			Approximate Interval Between Onset and Death
Medical Examiner	Examiner	disease or condition resulting in death) a. Coulous Hotel Difference Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):								
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oe e icial buri	g	resulting in death) Last Due to (or as a consequence of): d.								
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat g ☐ Unknown	eath 3 🛚	Ectopic pregnanc Other (specify)	у		2	23d. Date of delive	rery Day Ye ar
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he Hospi in 24 hou he Funer: pleted fill	Medical	(Check 2 Medical Examin	cian: To the best of my knowledger: On the basis of examination and Practioner: To the best of my kn	id/or inves	tigation, in my opinio	n, death occurred at	the time, date ar	nd place,	and due to the ca	ause(s) and manner stated.
Tot with Tot	_	29b. Signature and title of certifier	6		29c. License	70076	:	29d. Date	e signed (Month,	Day, Year)
21		30. Name and address of person who co	mpleted cause of death (Item 23	a) (Type, F	Utham	wood	Rd, Ste	204	Park	wille, Mb.
Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signature	1					,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gayle, L, Hams id 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner or Location of Death 4c. County of Death / Medical Itimore Baltimore Cit Age (In yrs. last birthday)
57 Yrs. **Funeral** If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M M 2 Months Hours Min. Country Director Usual Residence of Deceden 28a-f show 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 □ No ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 2/21. 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces' Completed by 1 Never Married 2 Married 9 Black, White, etc. Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No "natural", 3 Widowed 4 Divorced Specify: Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. I other than "vent, the Mer (Give kind of work done during most of working life. DO NQT use retired) Elementar Seconday (0-12) College (1-4 or 5+) Be (Father's Name (First, Middle, Last, Mother's Name (First, Middle, Maiden Surname) lith and Mental H 27 is marked or r traumatic eve ည 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health atem 27 i Batto. Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature uneral Service Licer 22. Name and Address of Facilit ton Pacs Patto ms 21239 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or neart failure. List only one cause on each line. 23a, Part 1 Approximate Interval Between Onset and Death Immediate Gause (Final Ph_sician/ renal disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to was a consequence of Cause (Disease or linjury that initiated events burial-trans ovanan cancer resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be 68760 the as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death use 23b. Was decedent pregnant Box (23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy for 5 Other (specify) Month Day the P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, cate has been sig ; page 2 should b 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The perform certificate 1 ☐ Yes 2 ☐ No ☐ Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 Tes 2 X No Other: Inpatient 2 ER/Outpatient 3 DOA this 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1X Natural 5 Pending injury work? n 24 hours after death. e Funeral Director: A eleted filled in by the fu 2 No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completed within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Bond MD MPI 1881853695 06,12,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dept of OB/GYM Mercy medical Center 301 St Paul Pl Baltimore 21202 Virginia Bond MD 31. Date filed (Month, Day State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per fh g916 6-20-11 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N6 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11:55 PM MUNE ay 5 20 11 Eaina /Medical 4a. Facility Name (If not institution, give street, and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, August 9, Birthplace (State or Foreign Qountry) 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours Min Months 1 □ M 2 🔀 F -64-7873 MARYLAND Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, If a Marical Examination 2000. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo HIMORE MARULAND 10g. Citizen of What Country? Street and Number 10f. Zip Code 21229 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Completed by 1 ☐Yes 2 No 3 Widowed 4 Divorced Frican HMERICA 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19g. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -BAHINERE MEYLAND 21229 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ■ Burial 2 Cremation 3 Removal from State Memorial Park June 23,2011 Wood/AWN, MARYland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
NANCY M. WAILACE FUNERAL SERVICE
MANY 3405 W. FRANKlin Street BAHIMOR MARYAND 21329 elece 23a. Part 1 Intervie disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILHRE MENAL **Physician** 7 day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, eeral Director; After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy In the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ATTY CAPD 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CAF 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe PSA Division of Vital 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Dipatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Man er of Death 1 ➤ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MEDICAL P24067 2011 KESI Bon T 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Remar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) TUNE 0515 A M Hoev Georgene 2011 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death HOSPITAL BALTIMOKE SAINT AGNES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, May 27, Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) Days 1 M X F 402-42-7234 1932 79 May_ Kentucky Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1029 Pine Heights Avenue 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Adkins George Helen Tackett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Jacobs (Daughter) 1029 Pine Heights Avenue Baltimore, MD 21229 20b. Place of Disposition (Name of Baftimore Crematory @ Loudon Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/21/11 Baltimore, Maryland 21. Signature of Funeral S Fice Li Ingle 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Pag 1. Enter the disease, complications that caused the shock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Months disease or condition resulting in death) Metastaho chondro sarcomo Due to (or as a consequence of): neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Pulmonary embolism resulting in death) Last Due to (or as a consequence of): Demenh IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes 2 🗹 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one)

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-tran P.O. Box 68760, signed by the aid Division of Vital Records. been si page 2 s certificate director. After this funeral

Examine Physician/Medical filled in by

Physician

Examiner

Funeral

Director

if than "natural", or items 23a or 28a-f show

ulth and Mental Hygiene. 27 is marked other than " r traumatic event, the Me

Department of Health ar Important: If Item 27 is any Injury or other trausone.

Physician

Examiner

/Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

10a. State

Director

Funeral

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Completed

Be

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δ Completed Be ပ္ Certification:

Medical

after death.

Director: Af
d in by the fur

To the Hospital or within 24 hours a To the Funeral D

State

5 Pending

investigation

6 Could not be determined

MD.

28a. Date of Injury (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Ave Bultimore

29d. Date signed (Month, Day, Year) JUNE 2011

21229

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Valikhani mohammad

Hospital:

900 Caton

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

31. Date filed (Month, Day, Year)

29b. Signature and title of Certifier

1 Yes 2 1 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

32. Registrar's Signature

ORIGINAL

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dav Voar 8.05 PM Hono tarn 2011 JUNE 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** N/A 8. Date of Birth (Month, Day, Year) TUNE 9,1955 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF 210-42-0612 Director 56 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director Yes 2 □ No N/A BALTIMORE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? death with 639 STREEPER STREET S. Funerai 21224 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Mamied Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No ş Q Specify: WHITE 3 Widowed 4 ☐ Divorced "natural", Completed injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) SECRETARY FUNERAL SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WASYL **HECNER** ည IRENE CHAMULACH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health an Important; If Item 27 Is any Injury or other trau once, MICHAEL HECNER/ BROTHER 639 S. STREEPER ST., BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ST. MICHAEL'S UKRAINIAN 6/21/11 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility LTLLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac **Physician** disease or condition resulting in death) minutes /Medical Due to (or as a consequence of): **Examiner** DOWE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last V.m.Z Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy funeral director, page 2 should be detached for Month Day Year 2 No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☑ №6 1 Inpatient 2 ER/Outpatient 3 DOA ပ 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be determined Director: 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral I the Hospitai 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 4940 Eastern Avenue, Baltimore, MD, 21224

DHMH 17 Rev 1/2001 11595

State

Registrar

31. Date filed (Month

rar's Signature

2011

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DNLS 20°/ 12:10 P LINE ame? Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** OWARI JUMN LSSUF 7. Age (in yrs. last birthday) Yrs. 8. Date of Birth 9. Birthplace Security Number (State or Foreign Funeral Months Davs Hours Month Day, arolina Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits them 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director HOWAR 1 🗌 Yes 2 🕱 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1791 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 If Yes, Give
Year or Dates. Black White etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surpame ည GOODSON aMIN MNO OV 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2019 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau NOU WITE drei 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State /WMb124 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 100 2079 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): -transit Exami and Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical The law requires that the death certificate be P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown the 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 100 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 Yes 2 No Yes 2 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospita 1 Tyes Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA esidence 6 Other (Specify) Director: After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending work?
1 Yes atural 5 Pending hours after death. 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital To the Funeral Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause tem 23a) (Type, Print) 5450 Knoil North Drive 31. Date filed (Month, Day, Year State Registrar 2104

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0655 Medical Facility Name (if not institution, give street and number 4c. County of Death Examiner MOR mo If Under 24 Hrs. **Funeral** Age (In yrs. last birthoay) Birthplace (State or Foreign Min. 1 M 2 D F Hours (Mon Director Usual Residence of Decedent 23a or 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-1. Marital Status 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, Black, White, etc. 1 Newer Married 2 Married should be filed within 72 hours after Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", If Yes, Give 3 ₩Widowed 4 □ Divorced Year or Dates. WW TJ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) ည Informant's Name/Relationship (Type, P. and Number or Rural Route Number, City or Tow 0 Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 cemetery, crematory or other place, oval from State Donation 5 Other (Specific any 23a Part 1. Enter the disease, or complication shock, or heart failure. List only one of ons that caused the death. Do not enter use on each line. Approximate Interval Between Onset and Death 2 Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner weeks Se uentially list conditions if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events well burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 nding physi use as the k IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autops 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Tes 2 No မ 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) amava U52016 2011 aitl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ba Utima Le 200 ZONY avel 32. Regist

Registrar

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. for State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ones 11, Virginia JUNE 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution,; give street and number) Examiner HOSPITAL F NIA BALTIMOKE BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) **Funeral** Months Min. Days Hours 1 M 2 V 242-04-722 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examination to other traumatic event, If a Medical Examination. 1 Pres 2 □ No Director MI altimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Ave He ghts 2121 108 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şecondary (0-12) College (1-4or 5+) Merc 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maggie nwood anr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 MD 21217 Kevs Hue Baltimore, Hattie 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Margarettsville → Other (Specify) 4 Donation 21. Signatur Funeral Service Licens Funera Batto. Heights Alle, 94600 Liberty 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner blood aspivation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner certificete be executed tacial Osteo sav co ma sician end burial-tran Due to (or as a consequence of) anding physician use es the burtal Taxto MEM. Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? The law requires that the death atter for u 3 🗆 Ectopic pregnancy Day signed by the a 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To this f. neral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 2 Accident 5 Pending investigation s a er death I Director: Af id in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours arer d To the Funeral Direct completely filled in by 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortifier H006810 11,2011 D. o 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF PRISCILLA M. SHOGAN D.0. SINAL 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** oseph 10:04 2011 June ١i /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 □**χ**M 2 □ F Yrs 214-18-9999 **Director** 89 Nov 11, 1921 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner miss because once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director **Baltimore** N/A Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 5537 Cedonia Avenue 21206 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Xes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1942 1 ☐ Yes 2 ☐ No Specify þ Black 3 Widowed 4 Divorced 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specily only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U. S. Postal Service Postal Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Kyler William Kyler ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5537 Cedonia Avenue Baltimore, Maryland 21206 Dorothy Kyler 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Deurial 2 Cremation 3 Removal from State 06/21/11 Owings Mills, Md. 4 Donation 5 Other (Specify) Garrison Forest Veterans Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury Examine Due to (or as a consequence of) that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? for Year Month Pregnant at time of death 5 Other (specify) 2 No P.O. the signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy has performed? Yes 2 🗌 No certificate Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one. examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1° Yes 2 □ No 1 X Inpatient 2 ER/Outpatient 3 🗌 DOA 2 After this funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury Certification: 5 Pending investigation (Month, Day or Attending 1 Natural within 24 hours after deatn.

To the Funeral Director: After completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide To the Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death)illim LAndrum Day Physician/ Month Year berl Medical 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 315 East Coldspring Lane Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral 1** M 2 □ F Months Days Hours Min (Month, Day, Year) 248-38-4860 Director 82 07 Usual Residence of Decedent 28a-f show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c City Town or Location 10d. Inside City Limits Director 1 Xes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21216 315 East Coldspring Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. þ Maryland 21215-0036 1 ☐ Yes 2 No Specify. SpecifyBlack 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Machinist Supervisor</u> Beth Steel Corp. <u>12th grade</u> permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important; If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F မ Lucilla Black William Landrum Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 East Coldspring Lane, Baltimore, Catherine Landrum-Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Owings Mills, Md 6/21/2011 Garrison Forest 21. Signature of Ingral Service Lice 22. Name and Address of Facility March F/H West 4300 Wabash Ave, 21215 Baltimore, Md 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Interval Between Onset and Death Immediate Cause (Final Debility Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Stroke Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury that initiated events Exami VASCULIN disease The law requires that the death certificate be executed pheral with non-Healing and -tran Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for us 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death Unknown Yes 2 No 9 Unknown P.O. signed by t d be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ with Dsychosis, Hypertensim Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen urinny tract intections Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perlipidemia performed death? this certificate retention thy 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Inpatient 2 I ER/Outpatient 3 I DOA After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director, Af
completed filled in by the fu 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital or Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier N-Chales St. Balto and 2120x 30. Name and address of person who completed cause of death (Kem, 23a) (Type, Print) G-BMC 6701

State

Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

Barres

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Physic		1. Decedent's Name (First, Midd	le,Last)					2. Date of Dea Month		Von	3. Time of Death
ledical Exam	iner	OHGE TOD		chael		Lessa		June 16, 2		Year	1400 hrs
		4a. Facility Name (if not institution University Hospital	on, give street and numbe	er)	4	b. City, Town, or L Baltimore	ocation of Death		4c.	County of Dea	ıth
Funeral		5. Social Security Number	6. Sex 7. A	Age (in yrs. last b	irthday)	If Under 1 Year Months Days	If Under 24Hrs Hours Min.	_	rth (MM/I	DD/YYYY) 9. B Fore	Birthplace (State or eign
Director		069-46-3450	1XM 2F	55	Yrs.	Indiana Bayo	110410	07	14	55 °	Country) NC
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location	on					10d. Inside City Limits
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Maryland 28a-f show d at once.	Director	10e. Street and Number	-			10f. Zip Code		1	l 0g. Citiz	zen of What Co	•
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21215-0036 Muld be filed within 72 hours after death with Mental Hygiene. marked other than "natural", or items or event, the Medical Examiner, must be	BB B	Homer D. Less	sane				Geraldi	ine Ga	ddy		
(A 2 < 10	유	19a. Informant's Name/Relations	ship (Type, Print)	1	9b. Mailing	Address (Street	and Number or F	Rural Route Nur	nber, Cit	ty or Town, Stat	te, Zip Code)
i, MD and 2 sho ealth and tem 27 is traumati		Geraldine Les 20a. Method of Disposition	ssane-Moth	er 20b, Place	3333 of Disposit	Edmond:	son Ave	Bal Date	t i m	ore. Mocation - City of	id 21229 or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		1 X Burial 2 Cremation		Jiaio	atory or oth) = /2/21	, r.7		M all
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Physician Medical		23a. Part I. Enter the disease, d failure. List only one cause	on each line.			e mode of dying, s	uch as cardiac o	r respiratory arr	est, sho	ck, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Gunshot woun Due to (or as a con		so						Death
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	miner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con	sequence of):							
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760, icate be physici the burn	₩.	IF FEMALE: 23b. Was decedent pregnant in ti	23c. If yes, outcome	ome of pregnanc			7			. Date of delive	-
Box 6876: death certificate the attending phyed for use as the left.	ician/M	past 12 months?	I LIVE DITE	at time of death	- =	aldeath ³ <u></u> er (S <i>pecify)</i>	_Ectopic pregna	ncy		Month	Day Year
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ords, w requir s been s should!	letec							24a. Was			utopsy findings available completion of cause of
The law require finds the second of the seco						death?					
Vital Rec ysician: The his certificate director, page	BeC	25. Was case referred to medica examiner?					of Death (Check of	only one)			
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Division tal or Attendir rs after death.	ijca		stigation 28e. Place of	Injury - At home,	farm, street	, factory, office bui	ilding, etc.			nd Number or R	tural Route Number, City
Dispital opers a neral I	Ser	4 Homicide dete		ocal Street				or Town, S 525 N Deniso	n Stree	et, Baltimore,	MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici compleety filled in by the funeral director, page 2 should be detached for use as the burn.	<u>8</u>		hysician: To the best of one miner: On the basis of example and manner stated	amination and/or							
E 3 E 8	Medi	29b. Signature and title of certifie				29c. License			1		onth, Day, Year)
		mu	, , ,			O.C.M	.E.		June	17, 2011	
4		30. Name and address of person Ling Li, MD Assista	who completed cause of int Medical Examin			e Street, Baltir	more, MD 21	223			
	tate	31. Date filed (Month, Day Year)	32. Registr	s Signature	V. 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year MERLUS-MENDEZ USF 201 8: ZOPM 06 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Bultmane 6. S**y** 1 □ M 2 □ F Social Security Number Funeral 7. Age (In yrs. last birthday) 32 yrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Min. Months Hours Sept 5, 1979 Salvador Director Ε1 NONE Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a, State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director District of Columbia DC Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral El Salvador 5940 Piney Branch RD NW#307 20011 12. Was Decedent Ever in U.S.
Armed Force
?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 A Never Married 2 Married δ Maryland 21215-0036 1X Yes 2□No Specify: Salvadorian SpecifyWhite 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hyglene. 77 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Labor other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ HERMINIO MERLOS EVA LUZ MENDEZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5940~Piney~Branch~RD~NW~#103~Washington,~DCpermit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 20011 MARTA MERLOS (sister) Baltimore, 20a. Method of Disposition CEMENT EFPET ON TENERAL Date 20c. Location - City or Town. State Burial 2 Cremation 3 Removal from State 06/27/2011 | Santa Ana, Metapan Municipal METAPAN 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Santa Cruz Funeral Services, INC 21. Signature of Funeral Service Usens 600 Kennedy st, NW: Washington, DC 20011 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Dire to (or as a nonsequence of) cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events and resulting in death) Last Due to (or as a consequence of) burial physiclan s the burial Physician/Medical that the death certificate be Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year Yes 2 □ No signed by the aid be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page perform death? ☐ Yes 2 X No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ဂ္ဂ 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral Natural 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier AU417643561975 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. aren 27 Balton

State Registrar 32. Re

amend items 6,12 per fh g916 6-27-11 vt Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
amend item 2 per docertificate of Death

Reg. No. State Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **June** Day 3. Time of Death Physician/ Douglass Montague, Sr. М 1:50a May 13 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3514 West Caton Avenue 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2.□E Days Hours Min. Months Director 214-26-0771 Oct 21 1932 Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🛚 Yes 2 🗆 No **Baltimore** Maryland **Baltimore City** 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 3514 West Caton Avenue 21229 U.S.A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Mamed Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐xNo Specify: 3 Divorced Black Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Army Soldier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lillie Robinson Robert Hines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3514 West Caton Avenue Baltimore, Maryland 21229 Alice Montague 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 06/17/11 Crownsville, Md. Crownsville Veterans Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 212 shock, of heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) prostate cancel Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 ası been signed by the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Director: After this certificate has 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗐 ျှ 5X Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending work 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause. on and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Denmeade Samuel WD 401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June 2011 William Marburg 9:04 Francis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oak Crest Care Center Parkville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dec. 25, 1916 Months Days Hours Min. 1 X M 2 □ F NewYork 94 Director 141-18-4890 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland Director 1 🗌 Yes 2📉 No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8834 Walther Blvd. U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 24 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 🕅 Widowed 4 🗌 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Labor/Management Consultant Dept. of Labor Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be.
Department of Health and Menta
Important: If item 27 is marked
any injury or other traumatic ev. 2 Franz Francis Marburg Marten Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ross Flewelling 15 Orinda Vista Drive Trustee Oakland, CA 94605 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State National Memorial Pk. 6-18-11 4 ☐ Donation 5 ☐ Other (Specify) Falls Church 22. Name and Address of Facility Ruck Towson Funeral Rome, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician END STAGE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 thknown 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has autopsy performed? 1 Yes 2 No within 24 hours after death,

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation ☐ Acciden
☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) Wances 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 0 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Hilda Mae Mullineaux Jun 10, 2011 1:35 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death **Baltimore** Randallstown Seasons Hospice @ Northwest Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min 1 M 2 X 212-28-4460 80 Aug 28, 1930 MD Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at Director Marriottsville MD Carroll 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be uned where.

Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be Funeral 2571 Thompson Dr. 21104 U.S.A Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Midowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Principal's Secretary Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ John Milliom Bozzell Peachie Arbagast 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 375 Madison St. Frederick, MD 21701 Glenn Mullineaux Son 20a, Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Good Shepherd Cemetery 1 D Burial 2 Cremation 3 Removal from State Ellicott City, Maryland Jun 14, 2011 Donation 5 Other (Specify) navre of Fuveral Service Lice 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Ant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nediate Cause (Final Physician/ sease or condition resulting in death) eavs Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical P.O. Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No į Month Day Year Pregnant at time of death signed by the at d be detached fo 5 Other (specify) 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform 1 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) in ations Other: 2 **2** No 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work Natural 5 Pending n 24 hours area ne Funeral Director; Af 1 🗌 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. прleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 037573 June 11, 2011 30. Name and address of person who com use of death (Item 23a) (Type, Print) Battine MO MA 21204 ZIREN State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G917 //05/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 17, 20°1′1 7:38A MERVIN MCCOY MILLER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CLINTON PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign 6. Sex 1**XX**M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min NORTH CAROLINA Yrs. 1938 Director 242 54 3796 73 Usual Residence of Decedent 28a-f shov 10a. State Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XXIII MD PRINCE GEORGES UPPER MARLBORO 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 10410 WESTPHALIA ROAD 20774 UNITED STATES items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, At Pes 2 No
If Yes, Give
Year or Dates. 1961–82 Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2XXNo Specify: Specify: BLACK "natural", Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. UNIVERSITY OF MARYLAND Elementary/Seconday (0-12) College (1-4 or 5+) 12TH SUPERVISOR / ADMIN. SUPP. TECH U.S. AIR FORCE should be filed with and Mental Hygien 7 is marked other t other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ JOSEPH MILLER ANNIE HOOKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau CHRYSTAL T. RODRIGUEZ/DAUGTHER 703 DEL MAR CIRCLE WEST MELBOURNE, FL 32904 Baltimore, 206. Place of Disposition (Name of 20a. Method of Disposition 06/28/2011 20c. Location - City or Town, State cemetery, crematory or other place) **XX** Burial 2 Cremation 3 Removal from State MARYLAND VETERANS CEM. 06/22/2011 CHELTENHAM, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur ice ROBERT G. MASON FUNERAL HOME 1661 GOOD HOPE ROAD, SE WAS WASHINGTON, DC 20020 DONALD GRAY Enter the disease, or complications that caus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between k, or heart failure. List only one cause on each line Immediate Cause (Final disease of Indition Onset and Death Physician DDER Medical resulting in death) Due to (or as a consequence of) Examiner 2THUSTATIC Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events that the death certificate be executed and Due to (or as a consequence of resulting in death) Last burialphysician s the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown Unknown P.O. ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page perform 2 No 1 Yes 2 Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) No Hospital Other: ည 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at After t 28d. Describe how injury occurred Certificate: To the Hospital or Attending work? 1 Natural 2 Accident 5 Pending injury r death. 2 🗌 No Investigation Director: / 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) hours the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

within 24

Registrar

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 2 0 2011

of death (Item 23a) (Type, Print) 750

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene generated and state of Maryland / Department of Health and Mental Hygiene generated and state of Department of Department of Health and Mental Hygiene generated and state of Department of Health and Mental Hygiene generated and state of Department of Health and Mental Hygiene generated and state of Department of Health and Mental Hygiene generated and the state of Department of Health and Mental Hygiene generated and the state of Department of Health and Mental Hygiene generated and the state of Department of Health and Mental Hygiene generated and the state of Department of Health and Mental Hygiene generated and the state of Department of Health and Mental Hygiene generated and the state of Department of Health and Mental Hygiene generated and the state of Department of Health and Mental Hygiene generated and the state of Department of Health and Mental Hygiene generated and the state of Department of Health and Mental Hygiene generated and the state of Department of Health and Mental Hygiene generated and the state of Department of Health and Mental Hygiene generated and the state of Department of Health and Mental Hygiene generated and the state of Department of Health and Hygiene generated and the state of Health and Hygiene generated and the state of Health and Hygiene generated and the state of Health and Hygiene generated and Hygiene genera 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:48a.^M 06 2011 Medical 4a. Facility Name (if not institution, give street and milital mon Road 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Randalls Baltsmon nase If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In vrs. last birthday) 1**X** M 2 □ F Hours Min (Month, Day, Year) 58 **Director** (prevada 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Yes 2 🗆 No Kosvilly 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 212 4609 U.S.A. ral", or items death 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married Yes Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced Black Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 7th grade District Council Painter Decorator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ George Niles Eldice James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Niles-Wife 4609 Talman Road, Pikesville, Md 21208 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Memorial Park 6/20/2011 Woodlawn, Md permit. ture of Funeral Service Lice 22. Name and Address of Facility
March F/H West
4300 Wabash Av Baltimore. 23a. Paryl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause ____ach line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ 4201 Medical resulting in death) to (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) attending physician and for use as the burial-transit abe that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has performed 2 🗌 No 1 🗌 Yes Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature

Registrar DHMH 17 Rev 7/2009

State

Breybroo

who completed cause of death (Item 23a) (Type, Print) 3510

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, G916, 6/20/20/11, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar 959 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4b. City, Town, or Location of Deat 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner ASHINGTON WRK MONT GOMERY HOVENTIST Koma Social Security Number 578/870 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 6. Sex **Funeral** 1 12 M 2 □ F Months Hours Min. Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** ASHINGTON 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired), DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OSTA1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ OliveR 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 02 HIMO/R 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date matory 1 Burial 2 Cremation 3 Removal from State RENTWOOD, MD INCOLN 4 ☐ Donation 5 ☐ Other (Specify) 420 H ST. NE. WASH. DC, ZOOOL Signature of Funeral Service Licenses 22. Name and Address of Facility VOME emre 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ERE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XX Natural 5 Pending 1 Yes 2 🗌 No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a To the Funeral L Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Chan mD 12-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7207 Hanover Pkwy #B Greenbelt, MD 20770 Chandrasekhar Korapati 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Item 1 per dr.,g916,06/20/2011dhb

Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month HICE Year **Physician** 9:33 arru Russell une 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital Baltimore City 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** Days Hours 1X M 2 F 127-32-9774 70 **Director** 01/02/1941 NY Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ems 23a or 28a-f sh r must be notifled a Director 1 Yes 2 XNo PA Union Lewisburg 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Items 23a 686 Springhouse Drive 17837 U.S.A. Funeral death \ permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If frem 27 is marked other than any Injury or other traumors. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Information Elementary/Secondary (0-12) College (1-4 or 5+) Technology Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Robert Price Thelma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice L. Price (Wife) 686 Springhouse Dr., Lewisburg, PA 17837 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 T Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Conrath F.H. 6/6/11 Watsontown, PA 21. Signature of Funer I Service Licensee 22. Name and Address of Facility Conrath-Grenoble F.H. 13 308 Main St., Watsontown, PA 17777 23a, Part 1, Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart fa Immediate Cause (Final **Physician** disease or condition resulting in death) astrinkstinal /Medical Due to (or as a consequence of) **Examiner** irrohosis Sequentially list conditions, if any trading 1; immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-trar and Due to (or as a consequence of) by the attending physician Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No filled in by the funeral director, page 2 should be detached P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 XInpatient 1 ☐ Yes 2 No မ 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury Time of 28c. Injury at Work? 28b. 28d. Describe how injury occurred Certification: To the Hospital or Attending R within 24 hours after death.
To the Funeral Director: After 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation Injury 1 🗌 Yes 2 □ No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 - Homicide City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my calcing the state of the cause of 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO

DHMH 17 Rev 1/2001

State Registrar MD

32. Registrai's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Res-DOD

WR 2, 2011

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ DAVID ALFRED ROGERS SR TIIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY BETHESDA NATIONAL NAVAL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) 1 XM 2 □ F Călifornia Director <u>554-26-5196</u> Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 10b. County be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Vienna Virginia | Fairfax 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 22181 2418 Rocky Branch Road Vas Deceden Armed Forces?

Vas. Give 1967 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X☐ No Specify: Specify: White Completed 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Navy Marine Engineer Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Anne Cameron John Alexander Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6355 West Delmar Lane, Glendale, Arizona 85306 David Alfred Rogers, Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Money & King Services 1 Burial 2X Cremation 3 Removal from State Cremation6/15/11 4 ☐ Donation 5 ☐ Other (Specify) Chantilly, Virginia Money & King Funeral Home, Inc. Signature of Funeral Service Licenses Downe W. Maple Ave., Vienna, Va. 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) spital or Attending Physician: The law requires that the death certificate be executed ours after death.

neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an performed 2 XN 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) 1 Tes 2 X No 욘 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 \sum Yes 2 \subseteq No Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending X Natural Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 1 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🔲 only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 2011 01241237 (VA) 06 NATIONAL NAVAL MEDICAL 0101241237

Registrar DHMH 17 Rev 7/2009

State

BETHESDA MD 20889-5600

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

MASSOUMI 31. Date filed (Month, Day, Year,

IIIN 2 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 16 Physician/ Month Doris Grace Roth 23:45M June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Union Memorial Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday of billingth, Day, Year Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days Hours (Month, July 088-14-3046 Director 87 Virginia Usual Residence of Decedent or 28a-f show 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No MD. Baltimore Ruxton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 15 Ruxview Court 21204 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, à 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 - Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Technical Writer US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary La Velle Jones Joseph Gordon Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a Bollinger/ Daughter Christine 2115 Forest Ridge Rd. Timonium, MD. 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date injury or o 1 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Co. 6-20-11 Towson, MD. 22. Name and Address of Facility Funeral Home, 21. Signature of Funeral Service Lig 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each li-Interval Retween Immediate Cause (Final Onset and Death Physician/ 24 Diralom disease or conditi-resulting in death) Medical Examiner 2 months Sequentially list conditions, cause. Enter Underlying Examir that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) ___ Day Year 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, the Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number AT2438946 30. Name and address of person ed cause of death (Item 23a) (Type, Print) acsueline 201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death David Allen Rund Sr. Month Physician/ 340pmM 06 201 Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Franklin Square Hospita Kosedale Baltimore If Under 1 Year If Under 24 Hrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213-84-0328 1 ፟ M 2 □ F Days Hours Min. (Month, Day, Year) Country) 45 Director Sept Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at Director MD Baltimore Essex 1 Yes 2 No 10f. Zip Code 21221 10e. Street and Number 10g. Citizen of What Country? Funeral 1056 Middleborough Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Pro-Co Enterprises Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ruth Ruth Lambert Rund 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1056 Middleborough Road Balto. MD 21220 /wife Tina Rund 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBuriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Gardens of Faith 6/21/11 Rossville MD 21. Signatur A Funeral Sacrive Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ventricula disease or condition Medical resulting in death) Examiner Sequentially list coulding if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cardiamyo attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Encephalopathu 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 🏡 No 24a. Was an autopsy performed? Yes 2 X No has certificate 25. Was case referred to medical Be l 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this funeral 28a. Cate of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) 0053699 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

9000 Franklin Square Drive,

Shinners

Dr. Daniel Sh 31. Date filed (Month, Day, Year)

JUN 2 0 2011

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ 11:18 UNE 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTMORE NIA SINAI HUSPITAL OF BALTIMORE CITY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 69 1 №M 2 🗆 F Min Month, Day, Country) 247-70-075 Director Usual Residence of Decedent items 23a or 28a-f show ier must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Nes 2 No Hmore 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral <u>carman</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status "natural", or ite Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 If Yes, Give Year or Dates. 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Nidowed 4 ☐ Divorced Army the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NQT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than 'iury or other traumatic event, the Me jury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) room Be 17. Father's Name (First, Middle, Last) မ mit Ferris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce, altimore rervi slumbu 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Neurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 24/2011 Mills 4 ☐ Donation 5 ☐ Other (Specify) Wings - where of Funeral Service Licensee 1600 Hei9 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ MYOCARDIAL NFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner IDAY HYPOXIC RESPIRATORY Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi): burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last physiciar Physician/Medical that the death certificate be Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death Yes 2 No 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ (ORONARY Records, ARTERY DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available CARDIO MYOPATHY 24a Was an prior to completion of cause of death? page 2 performed Yes 2 2 No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical funeral director, To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes_ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h. Time of 28c. Injury at work? Certificate: 1 Natural 5 Pending s after death. 2 🗌 No 1 🗌 Yes Investigation Could not be 2 Accident filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month. Day, Year) June 14, 2011 M.B.B.S KESOOD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KO M.B.B.S AN HOSPITAL OF MMANUEL 32. Registrar's JUN 2 0 201 Year) State Registrar

DHMH 17 Rev 7/2009

ROBER

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mabel Margaret Schuller ^D2011 Physician/ -Schuller Mable Margaret June 14. 4:56 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Cockeysville Maryland Masonic Home If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours 1271171917 Mary land Director 215-03-5364 93 Usual Residence of Decedent fshow 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at filed within 72 hours after death with the Maryland Director Maryland Baltimore Cockeysville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 300 International Circle Rm # 130 21030 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ₩idowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medicall any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Not Known Frank Smith Matilda M. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20315 Middletown Road Freeland, Maryland 21053 Joanne L. Stover / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 KBurial 2 Cremation 3 Removal from State 6/17/2011 Timonium, Maryland Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Signature of Fyneral Service Licenses 1050 York Road Towson, Maryland <u>21204</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final + Liver mases - presimed Com cer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Dav 1 Yes 2 9 Unknown 2 No this certificate has been signed by the all director, page 2 should be detached Unknown Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hy pertiese 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death nours after death.

neral Director: After the filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 6 24 hours a within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 2 6-16-11 o completed cause of death (Item 23a) (Type, Print) Ben St 8018. cm Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death Physician/ Month Schmanske 2011 11:48PM June Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Bon Secours Daitmore Social Security Number If Under 24 Hrs. Year 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday **Funeral** Months Hours Ma(140th ^D67, Year) 915 1 X M 2 🗆 F Director 215-10-7373 96 Maryland Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Baltimore MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21228 815 Winters Lane, Apt. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married X Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Peacetime 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) 12 College (1-4 or 5+) Westinghouse Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Belle (Unknown) Schmanske August 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 269 Berrywood Dr., Saverna Park, MD 21146 Robert Smith (Nephew) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 6/22/11 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Louison Fark Funeral Force 21. Signature of Funeral Service Licen 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, affock, or heart failure. List only one cause on each line. Approximate Interval Between Upper Gastro Intestinal Immediate Cause (Final Qnset and Death Physician disease or condition hours Medical resulting in death) (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 3 \square Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by cardioVascular 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Congestive heart failure 24a. Was an certificate has performe Yes 2 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 Renoutpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 attending Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 0 2011

2000. W. Bathmore

Bon Scious Hosp

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

merald Smith	State of Maryland / Department of Healt 1-For State		giene Reg. 1	No. 2011	19599			
Physician/	Decedent's Name (First, Middle,Last)		Date of Death Month Da	av Year	3. Time of Death 0019 hrs			
Medical Examine	Indiata information of the cir	own, or Location of Death	June 14, 201	1 4c. County of Death	00191115			
	University Hospital Baltim			n/a				
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unde	r 1 Year If Under 24Hrs.	8. Date of Birth (N	MM/DD/YYYY) 9. Birti				
Director	215-41-6901 1 M 2 X F 17 Yrs. Months	Days Hours Min.	3/28/19	94 Foreign	n Intry) MD			
	Usual Residence of Decedent							
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f sho	MD n/a 1200 Glyndon A				1 X Yes 2 No			
the Maryland a or 28a-f show tified at once	10e. Street and Number 10f. Zip		10g.	Citizen of What Coun	try?			
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or items 23	1 Never Married 2 Married Armed Forces? If Yes, specify	nt of Hispanic Origin? (Spe / Cuban, Mexican, Puerto F		White, etc.	all illulari, black,			
77	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2	X No specify:		Specify:	White			
ours aft	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual (Occupation (Give kind of we		6b. Kind of Business/Ir	ndustry			
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5-0036 ed within 72 hour bygiene. other than "natu the Medical Exan	9 Student	Lagran a N	(First Maintella Marie	Student				
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To the Topic or other traumatic event, the Medical Examiner must be notified at once To the Topic or other traumatic event, the Medical Examiner must be notified at once and the state of the complete of the Topic of the Complete of the Topic of the Complete of t	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	(Street and Number or Re		r, City or Town, State,	Zip Code)			
AD 2 sho	Mary K. Smith / Mother 1200 Glyr	ndon Avenue,	Baltimor	e, Marylar	nd 21223			
그 경우 등 등	20a. Method of Disposition 20b. Place of Disposition (Nam 20b. Place of Disposition (Nam 20c. Place of Disposition (Nam 20	ie of cemetery,	Date 20	0c. Location - City or	Town, State			
Baltimore, permit. Pages I an Department of Hee Important: If ite injury or other tr	1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Loudon Park Ce	metery 6/1	7/2011	Baltimore,	Maryland			
Baltimo permit. Page Department of Important: injury or ott		Address of Facility Hub	bard Fun	eral Home,	Inc.			
0 88 1	4107 W	Wilkens Avenu	œ, Balti	more, Mary	land 21229			
Physician (Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line.	f dying, such as cardiac or	respiratory arrest,	shock, or heart	Approximate Interval Between Onset and			
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J. Box 68761 t the death certificate by the attending phy sched for use as the b Physician/M.	1 Yes 2 No 9 V Unknown							
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that the start death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Re Commission by D.			performe	ed? death? No 1 ✔ Ye	s 2 No			
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Division Bospital or Attent 24 hours after death Funeral Director: tely filled in by the		time, date and place, and	due to the cause(s	s) and manner as state	əd.			
Division of Vital Records, P.O. Box 6876(To the Hospital or Aftending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicianly filled in by the funeral director, page 2 should be detached for use as the bearding filled in by the funeral director, page 2 should be detached for use as the bearding filled in by the funeral director, page 2 should be detached for use as the bearding filled in by the funeral director, page 2 should be detached for use as the bearding filled in by the funeral director, page 2 should be detached for use as the bearding filled in by the funeral director, page 2 should be detached for use as the bear filled in by the funeral director.	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my and manner stated.							
E > E 8	29b. Signature and title of certifier 29c	c. License number	1	29d. Date signed (Moi	nth, Day, Year)			
	(iluun V/)	O.C.M.E.		June 14, 2011				
4	30. Name and address of person who completed cause of dear typer 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223							
		e Street, Baltimore,	IVID 2 1223					
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	44				OCME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ TUNG Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Baltimore 0000 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛂 Months Days Hours Min. (Month, Day, Country) QQDirector Usual Residence of Decedent 28a-f shov 10b. County 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Dyes 2 DNo itimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 2116 ural", or items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Rlack. White, etc. þ 1 Never Married 2 Married 2 100 Yes Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 ₩idowed 4 Divorced "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Department of Health and Mental Hygiene. Important; If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sing 10 Be 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) မှ Page 1 and 2 should be ment of Health and Menta Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) HURO Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Nurial 2 Cremation 3 Removal from State 6/18/2011 Baltimore butus 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility wel ALLe Balto MDZIO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. Chresnom disease or condition MUTHENTIC Lynb 14 EVAY Medical resulting in death) Due to (or as a consequence of): Examiner CHIUMIC 30 767175 OBSTAN Sequentially list conditions. Examine Due to (or as a consequence oi). it any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No sate has been signed by the page 2 should be detached Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CAHAID WASCULAR 10 5 c 47 67 C 1. Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' ☐ Yes 2 ☐ No 1 Yes 2 No within 24 hours after death,

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital _2 🌠 No 1 Tyes မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 PResidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 🗌 Yes 2 \square No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical 29a Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) Im SOYOSA

Registrar DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's

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WINGTOW

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 10 sune 2011 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 6505 Woodgreene Circle Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days **Director** or 28a-f show 10d. Inside City Limits filed within 72 hours after death with the Maryland raumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director Yes 2 □ No imore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral items 23a een Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 9 þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) College (1-4 or 5+) SERVICES OCIa 1 Be 17 Father's Name (First) Middle, Last) Mother's Name (First, Middle, Maiden Surname) and Mental Fishered of Department of Health and Menta Important: If item 27 is marked: any injury or other traumatic conce. မ Mullen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura Route Number, City or Town, State, Zip Code) 0115 6505 1 You Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility m31201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Breast cancer Onset and Death Ph_sician/ month disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed led by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗶 No Month Day Year Pregnant at time of death Unknown g Unknown been signed by tashould be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by artery disease Coronary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Penal Discase 24b. Were autopsy findings available prior to completion of cause of death? End-stage 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ပု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Do.



DHMH 17 Rev 7/2009

State Registrar on bus, MD

Yim, MD

31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signatu

D51807

419 West Redwood Street, baltimore, Maryland 21201

June 16,2011

11-04508	
Louis Wilson	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 0 1 9602 State of Maryland / Department of Health and Mental Hygiene

Physician December's Name (Frist, Midde, Last) 2 Date of Death 2 Date of Death	ale Trilledi.		- For State Celegistrar	ertificate of Death	Reg. No.	
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. June 17, 2011	Rec The l ficate l	5		26 Place of Death (Check		es 2 No
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O.C.M.E. June 17, 2011	o the Journal of the	dica	one) 2 Medical Examiner: On the basis of examinatio	on and/or investigation, in my opinion, death occurred	at the time, date and place, and due to t	he cause(s)
and the section of person who completed cause of death (Item 23a)	F % F 8	Me	29b. Signature and title of certifier	4		onth, Day, Year)
30. Name and eddress of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223			MI	7	Julie 17, 2011	
	nv		30. Name and eddress of person who completed cause of death (II Russell Alexander MD. Assistant Medical Ex	aminer 900 W. Baltimore Street, Baltin	more, MD 21223	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signing of	,	tate	31. Date filed (Month, Day Year) 32. Registrar's Sy	Mala		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 16 Day 2011 Roland Harrison Whipp, Sr. June 6:24 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4494 Bark Hill Road Union Bridge Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Year) 1939 Days July 11, Country) Maryland 217-36-2527 Director Yrs 71 Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll 1 Yes 2 X No Union Bridge 10e Street and Number 10g. Citizen of What Country? Funeral 4494 Bark Hill Rd. U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hyglene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify 3 ☐ Widowed 4 ☑ Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) laborer/crane operator 12 cement plant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Richard Milton Whipp Hazel B. Yingling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda L. Whipp-daughter 6838 Snow Goose Ct., Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Paul's Luth. Cem. 6/21/2011 Uniontown, MD 21. Signatur of Fyneral Service Lice Se 22. Name and Address of Facility Hartzler Funeral Home 6 E. Broadway, Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition ENTRICULAR BRILLATION Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause of the ca Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 No Yes 2 2 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: ဂ္ဂ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10061755 6/17/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POOLE RID HEMALATHA 700 A WESTMINSTER, MD 2(157 NAGANNA 31. Date filed-(Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

11-04578 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene John Rich Aull, Jr. 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day June 19, 2011 Year John Rich Aull Jr. 0138 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Earis Road @ Cambells Quarry **Baltimore County** 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Maryland Min Months Days Hours Director Oct. 26, 1983 215 08 2510 27 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 X No Maryland Baltimore Middle River 28a-f show 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21 Congressional Court 21220 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14, Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes White 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Yeer Specify: 含 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Sports Radio Elementary/Secondary (0-12) College (1-4 or 5+) ultimore, MD 21215-0036
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ortant: If item 27 is marked other than "
ry or other traumatic event, the Medical E narked other than event, the Medical Sales Advertising 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Rich Aull Sr. Laura Siejack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Lynch (Mother) 21 Congressional Ct. Baltimore, Maryland 21220 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Bayview Crematory Inc. 6/23/2011 Baltimore, Maryland 4 Donation 5 Other Specify. 22. Name and Address of Facility Signature of Funeral Service Licer Bruzdzinski Funeral Home P.A. Maryland 21221 1407 Old Fastern Avenue Essex. Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical a. Multiple Blunt Force Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical ttending physician a UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy 1 Live birth Year Month Day past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 ✓ No 3 Probably 4 Unknown certificate has been sign ector, page 2 should be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) uneral director, examiner? Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes 2 No After 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Jun 19, 2011 1 Natural Passenger auto fixed object collision 0129 hrs Pending 1 Yes 2 ✔ No within 24 hours after death. Director: 2 🗹 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide _ Could not be or Town, State)
Earlis Road @ Cambells Quarry, Chase, Md. determined (Specify) Local Street Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. June 19, 2011 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State Registrar 31. Date filed (Month, Day Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 3. Time of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Alexander 201 3:15P^M Mae Sally Mav Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Prince Georges Fort Washington Health & Rehab Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Nov 28 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 💢 F Months Days Hours Min. South Carolina 245-46-391 96 191 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Director 1 X Yes 2 □ No Upper Marlboro MD Prince Georges 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral USA 20772 17233 Brookmeadow Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 XWidowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hill Sallie Mae Andrew 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 .7233 Brookmeadow Lane, UpperMarlboro, MD Margaret G.McKeithen/ 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 5/10/11 Charlotte, NC 4 Donation 5 Other (Specify) Oaklawn Cemetery 22. Name and Address of Facility AGEE/MCKINNON Funeral Service 21. Signature of Funeral Service Lice 3821 14th Street, NW, Washington, DC 20011 M00969 lace 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Cerebrovascular Disease disease or condition a. Acute Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transi Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Feeding Dysfunction s certificate has the lirector, page 2 s autopsy Chronic Renal Failure 1 ☐ Yes 2 📉 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner?
1 Yes 2 X No Other: 4 🕅 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) Hospital: ည 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) funeral 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the f Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State

29b. Signature and at le of certifier

V.

31. Date filed (Month Day, Year)

Edgar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Potter, MD

DHMH 17 Rev 7/2009

Registrar

29c. License number

1)42955

12017 Fort Washington Road, Ft. Washington, MD 20744

29d. Date signed (Month, Day, Year)

May 4,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 4:00 p M Allen June 18, Elmer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Hospice Center Towson Social Security Numbe Age (In yrs. last birthday) 1 Year If Under 24 Hrs. If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours october 28, 1929 1 XM 2 🗆 Maryland Director 213-26-8678 81 Usual Residence of Decedent show at 10a. State the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? d Mental Hyglene. marked other than "natural", or items 23a oi matic event, the Medical Examiner must be by Funeral USA 21219 7406 Bayfront Road Apt A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Fire Fighter Bethlehem Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Leroy W. Allen Ethal M. Pfeffer or other traumatic 2011 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Marissa Schott Granddaughter item 27 2748 Parallel Path, Abingdon, Md. 21009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot June ^D 22. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Oak Lawn Cemetery 2011 Dundalk, Maryland 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Signature of Fund al Service Licensee nthone 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Immediate Cause (Final Onset and Death NEUMONI Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ELMER ALLEN Completed by 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate h Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 X No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred injury X Natural 5 Pending 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OV JACKIE JONES, CRNP 2300 DULANEY VALLEY RD TIMONIUM. MD 21093

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

JUN 2 1 2011

32. Registrar's Signature

park

11-04491		Please Type or Print in Black Indelible Ink. Ensure	All Copies Ar	e Legil	ble.	
Herman Austín, Jr	1	State of Maryland / Department of Health and Certificate of Death			201	1 1960
Physician		Registrar 1. Decedent's Name (First, Middle,Last)		of Death		3. Time of Death
Medical Examine	er	Herman Austin Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Lo		15, 201		0607 hrs
	ı	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Lo Johns Hopkins Hospital Baltimore	cation of Death		4c. County of Deal	h
Funeral	4		If Under 24Hrs. 8. Da	te of Birth (MM/DD/YYYY) 9. B	rthplace (State or
Director	- 1	219-50-2558 1 M 2 F 61 Yrs. Months Days	Hours Min.	\$ 7	Fore	
	F	Usual Residence of Decedent	7 41	140, 0	1, 1, 1, 1, 1, 1	11.409/42
v any	Γ	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show	<u> </u>	Maryland N/A Baltinore		1.0		1 Yes 2 No
Mary rr 28a	Director	10e. Street and Number 10f. Zip Code			Citizen of What Co	
ith the		1821 Apple from Street 2/2/ 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispa				rican Indian, Black,
eath w	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No			White, etc.	
after d	교	3 Widowed 4 Divorced If Yes, Give Year or Dates:	specify:		Specify: B	ack
and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f she tranmater court, the Medical Examiner must be notified at once		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation during most of working life. Decedent's Usual Occupation during most of working life. Decedent's Usual Occupation during most of working life.			6b. Kind of Business	•
36 iin 72 iin 72 iin 42	D E	Elementary/Secondary (0-12) College (1-4 or 5+) Laborer			Jenne.	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Last) 18.	B.Mother's Name (First, M	/liddle, Mai		
215 be file ntal H.	8	Horman Austin, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street a	Evelyn 6	urnz	++	
D 21 hould hould Me is ma	۱≏	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street a	and Number or Rural Ro	ute Numbe	r, City or Town, Stat	e, Zip Code)
MD and 2 sho saith and em 27 is	-	Harry Davis - Brother 1821 Apple- 20a, Method of Disposition 20b. Place of Disposition (Name of cemel	ton St. Ba	LITIM 2	Oc. Location - City of	r Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other transit to more the Medical Examiner must be notified at once.		1 Purial 2 Cremation 3 Removal from State crematory or other place)			Baltima	
it. Pa	-	4 Donation 5 Other Specify: 21. Signifure of Funeral Service Licensee 22. Name and Address of	of Facility	6	1 50,00	in out.
Balti permit. Departu Imports		21. Sympture of Funeral Service Licensee 22. Name and Address of ACVIN TO SAIS Role: Nate 31. Acron National Service Licensee	WILLIAMS	lto,	mp 2/22	8
Physician	\top	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su failure. List only one cause on each line.				Approximate Interval Between Onset and
Medical Examiner	1	Immediate Cause (Final disease a Complications of blunt force l	head trauma	1		Death
	П	or condition resulting in death) Due to (or as a consequence of):				
	<u>آچ</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	amine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):				1
	ŭ	d.				
e exec cian ar rial - tr	S	☐ AMENDED 23a,pt.II,27,28a-f,per m	me,g920-10-	3-11	sm	
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed r death. retor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	7		23d. Date of delive	il and the second
C 68 certif ending use as		230. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 past 12 months? 4 Pregnant at time of death 5 Other (Specify)	Ectopic pregnancy	- I	Month	Day Year
BO)	S	1 Yes 2 No 9 Unknown 9 Unknown				
P.O. es that the igned by be detach	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give				the cause of death?
S, Fluires at the sign and be	8	Hypertensive Atherosclerotic Cardiovascular Di		a. Was an		utopsy findings available
aw rec aw see has bee	Completed	Cirrhosis of the liver		autopsy performe	prior to	completion of cause of
Rec The I ficate	5			Yes 2		es 2 No
ictan:	B.	examiner? [Hospital: 1 Insertion 2 EP/Outpatient 3 DOA Ot	of Death (Check only one Other 1 Nursing Home		sidence 6 Oth	ar.
Division of Vital Records, tal or Attending Physician: The law requin rs after cleath. al Director: After this certificate has been s' led in by the fineral director, page 2 should the fine of the	암	1 Yes 2 No 1 I I I I I I I I I I I I I I I I I I			v injury occurred	
on C ending ath. rr. Af	틸	Natural 5 Pending fd 5_30_11 unknown 1 Yes	es 2 X No sub	ject :	fell	
VISION Att	<u>≅</u>	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office buil	ilding, etc. 28f. Lo	cation (Stre	eet and Number or R	ural Route Number, City
Di ours a neral filled	Certification:	4 Homicide determined (Specify) unknown 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date	ŭi	Town, State 1 know	n'	
0 - 4 2	s) and manner as sta d place, and due to t	ited. he cause(s)				
To th withii To th	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dependent and manner stated. 29b. Signature and title of certifier 29c. License r			29d. Date signed (M	
		7.6/1/ O.C.M.			June 16, 2011	
	}	30. Name and address of person who completed cause of death (Item 23a)				
(2)		Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore S	Street, Baltimore, N	/ID 2122	23	

State Registrar 31. Date filed (Month, Day, Year) ORIGINAL

OCME

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2011 8:15 AMM Medical Clarence Brown June 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rising Sun

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Calvert Manor Healthcare Cecil Social Security Number Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F (Month, Day, Year) [ar 15, 1917 Director Delaware Mar 221-01-7014 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 456-B Lombard Road 21911 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education unic 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) farming permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Winter Day Brown Elsie Wherry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $463A\ Lombard\ Road\ Rising\ Sun,\ MD\ 21911$ Judi Brown/daughter 463A Lombard Road Rising Sun, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State 4

▼ Donation 5

Other (Specify) 21. Signature of Fundamental Service Licensee Nay r 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ plicemia disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burlal-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): nding physician use as the burlal Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Pregnant at time of death 2 No as been signed by the 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Disease. Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? page 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Hospital Other: မ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) achder 5 MD 6.13.2011. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Election MD21921

DHMH 17 Rev 7/2009

State Registrar 126A, E thigh

SAGIDEN MD

			Amend Item 25 per Please Amend Items 20 1 - State Amend Item Registrar	me,g916,06/21 Type or Print in I	/2011d Black In 16,06/1	hb delible in 672011d	ık, Ensı	ure A	II Copie	s Are	Legible).	
			For Amend Item	State of Marylan 23a,1 per dr	me 89]	rtment of [6,06/10 Tricate of	72011 d	ind iv	ientai Hy	giene	2011		0000
	DI		1. Decedent's Name (First, Wildale, Las	01/			Boutif		2. Date of De	eatn	- 4	. 3.	Time of Death
	Physicia Medic	al	James, Bel	James Chris	stopher				Month 3		01	11	СОЗО М
	Examin	er		yland Medical C	land Medical Center Baltimore							ath	Cara Foreign
	Funeral Director			ex 7. Age (In yrs. Ia	Yrs.	If Under 1 Year Months Days		Min.	8. Date of Bir		ountry M.	State or Foreign	
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	ne Mar or 28a- notifie	Director	MD 10e. Street and Number		Balti	10f. Zip Code				10a Citi	zen of What 0		Yes 2 No
	with the s 23a c	Funeral	718 W. Fayette	e St.		21201	L			_	JSA	ountry.	
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by	11. Marital Status 1 → Never Married 2 □ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2▼ No If Yes, Give	If	as Decedent of Yes, specify Cub	oan, Mexican	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)		14. Race - Am Black, Wh Specify: B]	ite, etc.	dian,
00-	hours a	letec	3 Widowed 4 Divorced 15. Decedent's E	Year or Dates. ducation	16a. Decede	ent's Usual Occu	pation				nd of Busines		
21215-0036	ed within 72 Hygiene. other than "r ent, the Med	Completed	(Specify only highest gra Elementary/Seconday (0-12) 12th	ade completed) College (1-4 or 5+)	(Give ki life. DC	ind of work done NOT use retired Tech	during most	of worki	ng		versi	•	
Maryland	ild be filed ' Mental Hyg iarked oth iatic event,	To Be	7. Father's Name (First, Middle, Last) Christopher J. Bell 18. Mother's Name (First, Middle, Maiden Surmar Louise Jennins										
Mar	12 should I Ilth and Me 27 is marl r traumati	32	19a. Informant's Name/Relationship (7)		1	Address (Stree							
Baltimore,	. 0		Cheyenne Webb 20a. Method of Disposition 1	20b. P	lace of Dispos	W. Fay ition (Name of atory or other pla leart C emetery	ace)	June	PatelO,	20c. Lo Ba1t	cation - City o	or Town, S	State
altir	permit. Page · Department o Important: If any injury or once.		21. Signature of Funeral Service Lisens		Zion C	emetery Name and Addr LVin B	ess of Facility	2011			dalk,		
8	o a L L L L L L L L L L L L L L L L L L	100	Carx		-114	14 6.	Prest	on	St. B	arto	Md.	2121	L3
-	Ph _{sician/}	250	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	plications that caused the death ne cause on each line.	1 0	the mode of dy	1996 as o	cardiac c	r respiratory a	rrest,		Inter	roximate val Between et and Death
-	Medical Examiner		resulting in death)	Due to (or as a conseque Hypertensi	,					. 17			
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. Box 68	requires that the death certificate be ex been signed by the attending physician should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3 🔲	Ectopic pregnar Other (specify)	ncy			23d. Date of de Month			Year
P.0	that the ned by e detac		Part II. Other significant conditions co	ontributing to death but not resu	ulting in the un	derlying cause g	given in Part I		23e. Did	tobacco u	se contribute	to the cau	use of death?
rds,	equires een sig ould b	ted							1 🗆	Yes 2			4 Unknown
Division of Vital Records,	The law ate has page 2	Completed by							24a. Was auto perf 1 \square Yes		prior to death	o complet	ndings available ion of cause of No
ital	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 1	Hospital:		_ lot	Place of Deat				—		
of V	g Physical this	te: To	27. Manne of Death	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Inju	ırv at		me 5 🗌 Res 28d. Describe			ecity)	· · · · · · · · · · · · · · · · · · ·
ion	tending l death. tor: After the funer	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b			M 1	Yes 2						
Divis	To the Hospital or Attending Physician: whith 24 hours after death and the Funeral Director. After this certific completed filled in by the funeral director.		4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify))					wn, State)			e Number,
	the Hospital thin 24 hours of the Funeral I mpleted filled	Medical	(Check 2 Medical Exami	sician: To the best of my knowle Iner: On the basis of examination se Practioner: To the best of my	and/or investig	gation, in my opir	nion, death oc	curred at	the time, date	and place,	and due to th	e cause(s)	and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier	AKI Palel, 1	ND	29c. Licen	se number 3228	411	C	29d. Dat	e signed (Mor	oth, Day,	^(ear)
_	(2)		30. Name and address of person who c	completed cause of death (Item 2 Sown GR	23a) (Type, Pr	street.	Balti	ma	es M	D ?	2120	1	
	Stat Registra		31. Date filed (Month, Day, Year)	0 2011 Registrar's Signat		park	,						

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend Items 25 327,28 a Per me, g 916,06/20/2011 dnb 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last 2. Date of Death Physician/ Month 2011 2:50 PM Medical Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death altimal 7 . Age (In yrs. last birthday) 8. Date of Birth 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months MD Yrs. **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director "natural", or items 23a or 28a-f sl dical Examiner must be notified 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2122 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. b 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. 3 ₩idowed 4 Divorced Completed Specify: is marked other than "natu aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Page 1 and 2 should be filed within 7 ment of Health and Mental Hygiene. tant: If item 27 is marked other than lury or other traumatic event, the M College (1-4 or 5+) ngineer Be Baltimore, Maryland 17. Father's Name (First Middle 18. Mother's Name (First, Middle, Maiden Surname) ပ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 alt more 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral Service Licens 22. Name and Address of Facility ant 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Examiner Due to lo signed by the attending physician and I be detached for use as the burial-transit CERTIFICATION POPROVED BY MEDICALE as a consequence of that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, or Attending Physician: The law requires 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate ☐ Yes Yes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes 2 Other 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Aursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending Division Investigation

Could not be 2011 1 Yes 2 X No Unknown M Probable fall within 24 hours after deal To the Funeral Director: Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Unknown Baltimore City, Maryland the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse at the time. 29b. Signature and title of certific Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 60 111012 M() Date filed (Month, Day, State Registrar

11-04367 Camille Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Camille Brown		- For State	Sta	te of Maryla		artment o e <i>rtificate o</i>			Mental	Hygiene	Reg. No	2011	19611	
Physician		Registrar 1. Decedent's Name (Fi	irst, Middle,	Last)			-			2. Date of De Month			3. Time of Death	
Medical Examine		Camille		A	•	Bro				June 10	, 2011		1128 hrs	
production of the control of the con	П	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital Baltimore									tc. County of Death ت	n/a		
Europal	4	5. Social Security Numb		. Sex	7. Age (In yrs.	last birthday)	If Under		If Under 24	Hrs. 8. Date of	f Birth(MM/DD/YYYY) 9. Birthplace (State or			
Funeral Director		_		1 M 2 X F	50	Yr	Months Days Hours Min. Foreign						n ,	
	H	217-74-44 Usual Residence of Dec	102	1 N 2			3.		<u> </u>	рере		7-559		
вий	T	10a. State 10b	. County			y, Town or Loca							10d. Inside City Limits	
Maryland 28a-f show 1 at once	5	MD	n/a		Ва	ltimor	e						1 X Yes 2 No	
the Maryland a or 28a-f sh tifled at once	<u> </u>	10e. Street and Number	r				10f. Zip				10g. C	itizen of What Cour	ntry?	
th the	<u> </u>	1022 Mc	Aleer					212			<u></u>	USA	La San Diegi	
r death with or items 23 must be no		11. Marital Status 1 X Never Married	2 Mar							(Specify Yes or I erto Rican, etc.)	No-	14. Race - Amen White, etc.	can Indian, Black,	
ter des				1 Yes ced If Yes, Give Ye				X No	specify:			Specify:	Black	
15. Decedent's Education (Specify only highest grade completed) 16b. Kin during most of working life. Do NoT use retired)										. Kind of Business/I	ndustry			
72 ho		Elementary/Seconda	ıry (0-12)	College (1-4 or 5+)			•		retired)			_	
17. Father's Name (First, Middle, Last)												_	America	
2121 bould be fi d Mental J is marked tic event,			Rainshaw Brown Mamie Barber a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2											
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alti mit. partm ports ury o		21. Signation 5				22.	Name and /	Address o	of Facility	NIGGS F	IINE	RAL HOM LTIMORE	E	
	1	0	<u> </u>	2	2		[412]	Ĕ.	PREST	ON ST.	BĀ	LTIMORE		
Physician ∛Medicar	ŀ	23a. Part I. Enter the di failure. List only o	sease, or co ne cause of	omplications that on n each line.	caused the deat	n. Do not enter	the mode of	dying, s	uch as cardi	ac or respiratory a	arrest, s	nock, or neart	Approximate Interval Between Onset and Death	
xaminer		Immediate Cause (Fina or condition resulting in		a. Narcot	ic (Met)		Intox:	cat:	ion				Dead	
	-	Sequentially list conditi		b.	a consequence	<u> </u>								
ğ		if any, leading to immed	diate	Due to (or as	a consequence	of):								
ted i msit		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):												
te be executed sician and burial - transit	<u>d</u>													
60, the executed sysician and burial - transi														
ficate ficate g phys		IF FEMALE: 3b. Was decedent preg	gnant in the	23c. If yes,	outcome of pre		atal daath	3 [Ectopic pre	anancy	2	3d. Date of delivery Month) Day Year	
Sox 6876(leath certificate e attending phy. for use as the b	2	past 12 months?		4 Pregi	nant at time of o	teath -	etal death other (Spec	fy)	_Lctopic pre	griancy		World	, c	
). Box 6876 the death certificate by the attending phyched for use as the Physician/M	<u>.</u>	1 Yes 2 No 9	Unkn	3 Oliki										
P.O. s that the		Part II. Other significa	nt conditlo	ns contributing t	o death but not	resulting in the	underlying	cause giv	ven in Part I.				the cause of death? bably 4 Unknown	
S, F													topsy findings available	
Division of Vital Records, I all or Attending Physician: The law requires rise death. al Director: After this certificate has been signed in by the funeral director, page 2 should be artification: To Be Completed.	2									au	topsy rformed	prior to o	completion of cause of	
tal Rec cian: The 1 certificate b ector, page	<u> </u>									1 ✓ Ye	s 2		es 2 No	
Sertifician:		25. Was case referred teaminer?	to medical	Hospital:	Innationt 2 a	ER/Outpatier			Whom C	eck only one) ursing Home 5	Posi	dence 6 Other		
of Vi Physi Per this eral dir	2 -	1 ✓ Yes 2 2 27. Manner of Death	No		of Injury	28b. Time of		"	at Work?			njury occurred		
ion of tending Pheath. tor: After the funeral		1 Natural 5		19 Fd 6	h, Day,Year) -10-11	fd 11:0)() am	1 Ye	es 2 X No	Unknov	vn			
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Division of spiral or Attending I spiral or Attending I spiral or after death. meral Director: After filled in by the funer form.	5	4 Homicide	determ		Reside	nce				Baltin	nore	1022 Mcal	eer Ct.	
		(0110011 0111)										and manner as state		
To the Hos within 24 h To the Fur completely		2 🛡			On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated. 29c. License number 29d. Date sign									
	-	29b. Signature and title	o centier	N.	/	,	Zac.	O.C.M		ME		d. Date signed <i>(M</i> o. I ne 1 1, 2011	ini, Day, Fear)	
		/ buode	- W	1. Ken	S JR	mace		J. J. 1V						
30. Name and address of person who completed cause(bit death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223														
Stat	е	31. Date filed (Month, D	Day, Year)	32. R	e strar's Signa	iture	arke	,						
Pogietre		111	IN T W	MARKET I	PR .	- 4	RIKEL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Registrar

State of Maryland / Department of Health and Mental Hygiene

23aPtI,II,25 per me, 9916,06/21/2011dhb

Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:20 A <u> 2011</u> <u>June</u> <u>Virginia Lane Brooks</u> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Forest Hill Under 1 Year | If Under 328 Montgomery Drive Cial Security Number 6. Sex 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 💢 F Dec. 6, 1927 Director 83 215-22-8340 Usual Residence of Decedent 10d. Inside City Limits be filed within 72 hours after death with the Maryland ntal Hygiene. 10c. City, Town or Location 10b. County 10a. State 28a-f show is marked other than "natural", or items 23a or 28a-f shot traumatic event, the "Modes Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Forest Hill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21050 328 Montgomery Drive Funeral Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: <u></u> White 3 ₩ Widowed 4 □ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Food Clerk 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Blanche R. Perry George Dewey Robinson P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2908 Smithson Drive, Forest Hill, Maryland 21050 Pages 1 and 2 s ment of Health ar John D. Brooks Sr./ Son portant; If item 27 / Injury or other to 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o Burial 2 Cremation 3 Removal from State Highview Memorial Gdn 6-15-2011 Forest Hill, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Parth. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration nontho Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Dementia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CAL EXAMINER Examine The law requires that the death certificate be executed NAPPROVED BY the burial-trar Due to (or as a consequence of) the attending physician CERTIFICATIO Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 🗆 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 Unknown the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No certificate has Urinary Tract Infection 2 NO 1 Yes Vital Physician: 25. Was case referred to medical examiner?
1 Yes 2 100 26. Place of Death (Check only one) Other: 4 \(\subseteq \text{ Nursing Home} \) Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To oţ After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death To the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident death within 24 hours after death To the Funeral Director; 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

resapeake Dr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month 34 ULLOCK 7 DANN Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. (Month, Day, Ye Year Country) 1 M 2 A Months Director 1956 288-66-0718 Sept Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland **Funeral Director** 1 ☐ Yes 2 🔀 No Arnold MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21012 USA 1512 Winterberry Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify. white Completed 3 Widowed 4 Divorced Medical unk 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, the unk unk Be unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001 Medical Parkway Annapolis, MD Anne Arundel Medical Center 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 🖫 Other (Specify) in state 21. Signature of Var Service Licensee Nay 10 ²² Name and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eat line. Interval Between Onset and Death Immediate Cause (Final Physician/ AICUNG disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Requestible list condition Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months? Year Month Pregnant at time of death 2 No Yes Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed peen . Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy 2 No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Tes 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29h Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 10

DHMH 17 Rev 7/2009

State Registrar PULISM DLIYU

ted cause of death (Item 23a) (Type, Print)

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Physician/ Month CALVERT ROSS BREGEL June 19 1:40P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Presbyterian Home of Maryland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 M 2 D F b2%16%1927 Mary and 219-22-7913 **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Tes 2 No Maryland| Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 400 Georgia Court 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married XXYes Yes, Give 2 NoWWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: 3 Widowed 4 XXDivorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ d Mental Hygiene. marked other tha Attorney Private Practice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Howard Calvert Bregel Edith Emily Hartley Health and Ntem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trae C. Ross Bregel Jr Son 401 West Chesapeake Avenue Towson MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date . Burial 2 **XX** remation 3 □ Removal from State GreenMount Crematory | 06/21/2011 | Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) nature of Funer 22. Name and Address of Parity chell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Unknown Yes 2 No been signed by the a should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autonsv 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No s after deau... al Director: Aftr Natural 5 Pending iniurv 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Funeral L 1 Secritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge death accounted at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 137016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kennih M. Green, mp 6701 N. Charles St., Sante 4104 Baltman, mp 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

11-04605 Linda Bell Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Inda Bell Brown	1- For State Registrar		tate of Maryla		artment o <i>rtificate o</i>		and Men		Re	eg. No. 20		19615
Physician/ Medical Examine		s Name (First, Midd Bell Bro		-				2	 Date of Death Month June 19, 2 	Day Year		3. Time of Death 1828 hrs
		lame (if not institution	on, give street and nu	ımber)		4b. City, Town, Hampste		of Death		4c. County of Carroll	f Death	
Funeral Director		4-7006	6. Sex	7. Age (In yrs. I	last birthday) 66 Yrs	If Under 1 Y Months D		ler 24Hrs.		th(MM/DD/YYYY) 27, 1944	Foreign	
à l	Usual Reside 10a. State	nce of Decedent 10b. County		10c. City,	, Town or Local	tion					1	10d. Inside City Limits
*	MD	Car	roll		Manch	ester						1 Yes 2 No
the Maryland a or 28a-f show tified at once. Director	10e. Street ar					10f. Zip Code			10	Og. Citizen of What TUrrited	at Countr	y? ates
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other transmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		Married 2XXM		orces?		Yes, specify Cub	ban, Mexican	n, Puerto R		White,		
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5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	Elementary	y/Secondary (0-12) 2th	College (1	1-4 or 5+)	Certi	fied Nu	rsina	∆ssi	stant	Nursino	a Hor	me
5-00 led wit Hygien tother the M		Name (First, Middle	, Last)		CCLCL	TIEG IVG	18.Mother	r's Name (I	First, Middle, M	laiden Surname)		iie
1121 Id be fill Aental F Aental F cvent, i		s Gamble	-Lie /Time Drint)		L 40b Mailin	- Address /Ci			Rodgers		Ct-to 3	0.14
AD 21 2 should 27 is ma To	1		(Husband	1		-				nber, City or Town		(ip Code)
l and l Health	20a. Method	of Disposition	n 3 Removal fr	20b. i	Place of Dispos	sition (Name of	cemetery,		Date	20c. Location - (own, State
Pages nent of ant: I		2 Cremation ion 5 Other S		om State AIJ	& Cre	ther place) s Crema matory		20	ne 21, 011	Manches	ster	, Maryland
3alti ermit. Separtri mport	2 Since re	of oneral Seri	21/2/	lar F	unera	Търе	el, P.A.					
Physician			r complications that co	aused the death						est, shock, or hear		Approximate Interval
/Medical xaminer	failure. L	ist only one cause ause (Final disease resulting in death)	on each line. a. Hyperte		Atheros							Between Onset and Death
		list conditions,	b	38.2000								
nin		g to immediate r Underlying Cause		a consequence of	rf):							
scuted and transit al Examine	(Disease or in events resulti	njury that initiated ing in death) Last	Due to (or as a	a consequence of								
tO, e be executed ysician and burial - transit	X UNPEN	NDED	X AMENDED I Items	Item# 10 #23a,27,)g,per j .per me	fh,g916 .g917 7-	6-21- - <u>11-11</u>	m				
OX 6876 eath certificat attending phy for use as the		edent pregnant in the nonths?	he 23c. If yes, the 1 Live b	outcome of pregi pirth nant at time of de	nancy 2 Fe	etal death ther (Specify)		ic pregnan		23d. Date of d Month	delivery Day	y Year
i, P.O. E ires that the d signed by the be detached d by Phy	•	significant condit	tions contributing to	o death but not re	esulting in the t	underlying caus	e given in Pa	art I.				e cause of death?
Records, The law requires firete has been signage 2 should be Completed									24a. Was a autops	sy pr m <u>ed</u> ? de	rior to con eath?	psy findings available mpletion of cause of
tal Reccion: The lar certificate ha ector, page 2		referred to medica	al I			26.Pla	ace of Death	(Check or	1 ✓ Yes 2 nły one)	!No 1 [✓ Yes	2 No
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Division o oppiral or Attending hours after death. Increal Director: After y filled in by the fune Certification:	3 Suicio	de 6 Coul		e of Injury - At ho	ome, farm, stree	et, factory, offic	e building, et	ic. 2	28f. Location (S or Town, St		r or Rural	l Route Number, City
To the Hospital within 24 hours To the Functal completely filled		outling .	thysician: To the bes aminer: On the basis of and manner s	of examination a								
To with To com	29b. Signature	e and title of certifie		taleu.	1	フ	ense number			29d. Date signed June 20, 20	•	ı, Day, Year)
			who completed caus Assistant Medic	10		- I Raltimore St	reet Balt	imore N				
State				editrar's appro-			Teet, Daiti	miore, N	710 21223			
Registrar	11IN 2	(Month, Day Year)	Charact 1	6. M								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 8 per fh,g916,06/21/2011dhb Certificate of Death 1 - For State Registrar 9616 Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ 5:14 uie enise Medical 4a. Facility Name (if not institution, give street and number 4b. City Town, or Location of Death Examiner 4c. County of Death 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Birthpia Country) Year) 1_982 1 M 2 F Months Min. May 8 Hours Director Usual Residence of Decedent 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f timore 1 Yes 2 No 10e. Street and Number ŏ 10f. Zip Code must be r 10g, Citizen of What Country? Funeral airmour 212 items 2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, the Medical Examiner 14 Black, White, etc. 1 Never Married 2 Married ö ģ 1 Yes 2 No
If Yes, Give
Year or Dates. 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 Divorced 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. tomema 1st Det artment of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once. Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ત ပ 100 ee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21,220 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date Page 1 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Furent omartie Beverl MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ do trema disease or condition resulting in death) Medical to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician a Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Day Pregnant at time of death Month Year been signed by the should be detached g Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performe 2 🗌 No Yes 2 N 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 Tyes Other: မ 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completed filled in by the fi pleted filled in by the f Accident Investigation 1 Yes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D0066614 Tune 16, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tennifer Berkeley MD Sinau Hospital of Baltimore 31. Date filed (Month, Day, Year) egistrar's Signature State

Registrar

11IN 2 1

backs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Physician/ 10:33 A.M 18 Norman Edward Bolander, Jr June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Manchester 3430 Augusta Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (St. (Month, Day, Year) June 17, 1933 Maryland Social Security Numbe 9. Birthplace (State or Foreign **Funeral** Min 1**XX**M 2 □ F Months Days Hours 78 Director 212-30-7357 Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2XXNo Carroll MD Manchester 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? United States of America Funeral 21102 3430 Augusta Road permit. Page 1 and 2 should be filed within 72 hours after death of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽXX No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. Korea 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Local 37 Engineers Heavy Equipment Operator 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Jennifer Viola Fowler Norman Edward Bolander, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3430 Augusta Rd., Manchester, MD 21102 Margo Bolander (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State 6/22/2011 All Faiths Crematory 4 ☐ Donation 5 ☐ Other (Specify) Manchester, Maryland 21. Signature of Juneral S. Dicerton name and Address of Facility Eckhardt Funeral Chapel, P.A. Manchester, Maryland 21102 3296 Charmil Drive, nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. Approximate Interval Between and Death Immedia Cause (Final Physician/ Ca yen disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Veal Day Pregnant at time of death n signed by the a Id be detached fo Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Ę. 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending Certifica 1 Yes 2 No Accident Suicide Homicide Investigation Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

within 24 hours after deat To the Funeral Director:

State

Medical

29a. Certifier

(Check

only one)

30. Name and address of person

31. Date filed (Month, Day, Year,

Registrar

death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State

Certificate of Death

sician and burial-transit requires that the death certificate be executed Box 68760 attending p for use as t signed by the a P.O. Records, has page of Vital Division

Baltimore, Maryland 21215-0036

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jumeth 14, 2011 3:20 P M Barbara Doris Borgyon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Edgewood 1810 Sandee Court Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2X- F Months Hours Feb. 10, 1940 077-32-2958 71 Director NY Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Edgewood must be notified at 10d. Inside City Limits Director Harford MD 1 Yes 2X No 10g. Citizen of What Country? o 10e. Street and Number 10f. Zip Code 23a 21040 1810 Sandee Court "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. Completed by 1 Never Married 2 Married within 72 hours after 1 ☐ Yes If Yes, Give X∏ No White 1 Yes 2 X No Specify: Specify: 3X Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 12 Elementary/Seconday (0-12) College (1-4 or 5+) Sales Manager Beauty Supplies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Irma Unknown Henry Marshall 19a. Informant's Name/Relationship (Type, Print)
Deborah Whistler-Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgewood, MD 21040 1810 Sandee Ct 20a. Method of Disposition
1

Burial Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 6/20/11 Glen Burnie, MD Ponation 5 Other (Specify) Atlantic Crematory 22. Name and Address of Facility Schimunek Funeral Home, Bel Air Signature of Funeral Service Licensee Q R 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ obs truction disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 02 -2011 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ putesion Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 XNo ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident (Month, Day, Year) injury 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRAYIHA MDIFACP 3640 Fords RIDA A. 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indalible lak. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 9:32 PM Asmi Dava Bharti-Dastidar une Zoll 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In vrs. last birthday Days 5 1 🗆 M 2 🗓 F Maryland 1 June 6. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Fairfax Vienna 1 Yes 2XX No 10g. Citizen of What Country? 10e. Street and Number 9104 Tetterton Avenue 10f. Zin-Code USA 22182 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: 1 X Never Married 2 Married Specify: Asian Indian 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Infant 17. Father's Name (First, Middle, Last)
Arjun
Arjun
Ghosh—Dastidar 18. Mother's Name (First, Middle, Maiden Surname) Manisha Bharti Arjen Ghosh-Dastidar Father Arjun 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9104 Tetterton Avenue, Vienna, VA 22182 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 Other (Specify) Atlantic Crematory 6/17/2011 Glen Burnie, Maryland 4 Donation 22. Name and Address of Facility Burgee Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211 Approximate Interval Between 23a. Part 1. Enter the dis shock, of leart failu Immediate Cause (Final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, leart failure. List only one cause on each line. Onset and Death Sepsis disease or condition resulting in death) Due to (r as a consequence of): Sequentially list conditions

Physician /Medical Exami

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item ZZ Is marked other 1 any injury or other traumatic event, the once.

Physician

/Medical

Examiner

N/A

Virginia

N/A

21. Signarure

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

the Medical

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

been signed by the attending physician After this certificate To the Hospital or Attend within 24 hours after death To the Funeral Director: A

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

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Medical Certification:

if any, leading to immediate cause. Enter Underlying Cause (Ursease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): C. Due to (or as a consequence of): d.		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1	ic pregnancy (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available
			autopsy performed? 1 Yes 2 \(\text{No} \) No 1 \(\text{Yes autopsy infollings available are prior to completion of cause of death?} \)
25. Was case referred to medical		26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 E	DOA Other: 4 - Nursing Hom	e 5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury 28b. Time of Injury Injury	28c. Injury at Work? 1 Yes 2 No	8d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, fac building, etc. (Specify)	tory, office 2	8f. Location (Street and Number or Rural Route Number, City or Town, State)
	ysician: To the best of my knowledge, death occur niner: On the basis of examination and/or investiga and manner stated.		and due to the cause(s) and manner as stated. and at the time, date and place, and due to the cause(s)

29c. License number

DODIOS

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

completely

29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 11:55 A M **Physician** 2011 06 RORIN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Levendale Hebrew Geriatric Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** 1**X** M 2□ F 9-6-1922 Ukraine Director 219-37-3326 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 XYes 2 No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 2 and 1 jury or other traumatic event, the Medical Examiner must be in once. 21215 United States 6968 Brook Mill Rd Apt. 2A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Media Journalist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown 2 Boris Borin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11801 Sweet Land Way Columbia, MD 21044 Michael Borin (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hampstead, MD Carroll Cremation 6-22-2011 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ELINE FUNERAL HOME 21. Signature of Funeral Service Licensee 11824 Reisterstown Rd. Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FAILURE CONGESTIVE **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No perform 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4₽ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide

e Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica within 2

Letertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

HITSICIAN

00064533

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE GERIATRIC CTR

2434 W. BELVESERE AVE BALTIMORE MOZIZIS AJANI BABATUNDE

Registrar

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month June 12:33 P M Davis 2011 Matt Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) **Funeral** 1 **X** M 2 □ F Months Days Hours March 30. Tennessee 409-60-7696 72 1939 Director Usual Residence of Decedent and 2 should be filed within 72 nours accession and Mental Hygiene.
If Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show items 27 is marked other than "natural", or items 23a or 28a-f show items 23a or 28a or 28a or 28a or 28a or 28a or 28a 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Bethesda Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 6208 Leeke Forest Court 20817 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 X Married <u>გ</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Department of the Elementary/Seconday (0-12) College (1-4 or 5+) Navy Physicist 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Christine Townsend Richard Davis Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6208 Leeke Forest Court, Bethesda, Maryland 20817 Linda L. Brown / Wife 20a. Method of Disposition
1 □ Burial 2 🏅 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) June 21, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite injury or Montgomery Crematorium, Inc. Bethesda, Maryland 2011 4 Donation 5 Other (Specify) 21. Sign per of Fundal Service Licenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 any M01305 Part 1/ Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Ventric Interval Between Onset and Death Physician/ Ventricular Fibrillation Medical resulting in death) Due to (or as a consequence of) Examiner Hvperkalemia Sequentially list conditions, it any, eaong to immediate cause. Enter Underlying Examine Duri to for as a consecuence of Renal Failure Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Sepsis IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death detached P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed the should be detailed þ Multiorgan Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy page 2 performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No certificate Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗓 No ည 1 X Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: injury X Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Siecen D68474 June 20, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Michael Siegenthaler, MD 8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State

DHMH 17 Rev 7/2009

Registrar

ROWN, MAITD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2 Date of Death Physician/ June ²011 William A. Barnes 15. 1:20 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3506 Calvend Lane Kensington Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign Min 1 🔀 M 2 🗆 F November 14, 1923 578-22-9325 87 Virginia **Director** Usual Residence of Decedent or 28a-f show 10a State filed within 72 hours after death with the Maryland al Hygiene. iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Kensington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3506 Calvend Lane 20895 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes 2 If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates. WWII th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) All-State Insurance Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Herbert Barnes Elma Grabil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Florence Laura Barnes/Wife 3506 Calvend Lane, Kensington, Maryland 20895 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June ^D#7. cemetery, crematory or other place)
Gate of Heaven
Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda, Chevy Chase Inc. Bethesda, Maryland 20814 7557 Wisconsin Avenue M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Parkinson's Disease disease or condition vears Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within £2 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Alzheimer's Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hyperlipidemia 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 K No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred X Natural 5 Pending 1 🗌 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Caused I allen in D0026607 June 16, 2011 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Edward Cullen, MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

7625 Wisconsin Avenue, Bethesda, Maryland 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 19^{Day} Rosemarie E. Bushman Month 2011 Year 3:00 A. M June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore **Examiner** 4b. City, Town, or Location of Death Gilchrist Hospice Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 2, 9. Birthplace (State or Foreign **Funeral** Months Hours 1 □ M 2 XX 79 212-30-7969 Yrs ^{Year} 932 Maryland **Director** Usual Residence of Decedent show 10a. State 10b. County or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Towson Baltimore Maryland 1 Yes 2XXNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America Funeral 21204 7700 York Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ※ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. white þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Je filed with. ⁴al Hygiene. ✓ar than "r (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working College (1-4 or 5+) Elementary/Seconday (0-12) Kernan Hospital 12 Personnel Director d 2 should be filed with alth and Mental Hygier 27 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surpame)

Jeannette Rosenberger ဂ္ဂ Robert E. Bushman traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Department of Health at Important: If item 27 is any injury or any Emilie M. Bauereis/ friend 2311 Poplar Drive Baltimore, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 24. 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2011 Parkville, Maryland Signature of Fundral Service Licensee 22. Name and Address of Facility Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph. sician/ disease or condition Medical resulting in death) a consequence of Examiner ۵ Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) executed that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician s the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 2 No Unknown 9 Unknown Division of Vital Records, P.O. þ signed to Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? page certificate 2 No 1 Yes Yes 2 -No Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 I NO ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. s a er death. I Director Aff d i by the fur Accident Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a er
To the Funeral Dure Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) 71040 H SM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 SUTTE 4105 N CHARLES KUMAR ST 1. Date filed (Month, State

Registrar

			Please	Type or Pri								•	
			For State Registrar	State of M	arylanc		rtment tificate			Mental Hy	/gien Reg. N	ZUII	19624
	Physicia	n/	1. Decedent's Name (First, Middle, La	H•		Dlar	nkensh	in		2. Date of De Month		2011 Year	3. Time of Death
	Medic	al	Elizabeth 4a. Facility Name (if not institution, give	June		c. County of Death	7:55 A ^M						
1	Examin	er	Upper Chesapeake		enter		Bel.		Location of Death		4	Harford	
	Funeral		Social Security Number 6. 8		e (In yrs. las	st birthday)	If Under 1		If Under 24 Hrs. Hours Min.	8. Date of Bi	rth	9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent	□ M Z LAF	62			,		(Month, De December	6,1		land
	Maryland 18a-f sho tified at	Director	Maryland Balti	more		Dunda.							10d. Inside City Limits 1 ☐ Yes 2 💆 No
\sim	with the l 23a or 2 1st be no		10e. Street and Number 7847 Harold Ro	ad			10f. Zip C		1222		10g. C	Citizen of What Cou	intry?
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.			Vas Deceden Yes, specify		spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)		14. Race - Ameri Black, White, Specify: Whi	etc.
/ <i>O</i> / 215-0	n 72 hour an "natu Medical	Be Completed by	15. Decedent's Elementary/Seconday (0-12)	Education rade completed) College (1-4 or 5	(1)	(Give k	ent's Usual C ind of work of NOT use re	done di	ation uring most of wor	king	16b.	Kind of Business Ir	ndustry
7	withii giene ner th t, the	ဝ	10 years		, , ,	Н	ousewi	fe_				Own Home	
### 10 0 0 0 0 0 0 0 0	ild be filed Mental Hy iarked oth atic even	To B	17. Father's Name (First, Middle, Last) Michael Lachaczyk			_			18. Mother's Nar		, Maidei	n Surname)	· · · · · · · · · · · · · · · · · · ·
	and 2 shoul Health and I em 27 is ma		19a. Informant's Name/Relationship (1) Jim Blankenship	Type, Print) Son								or Town, State, Zip Maryland	
Baltimore,	Page 1 a ment of H ant: If ite ury or oth		20a. Method of Disposition 1 → Burial 2 → Cremation 3 → 4 → Donation 5 → Other (Spec		20b. Pla cer Sacr	ace of Dispos metery, crem ed Hear	sition (Name natory or othe tof Me	of er place try C	June Jem. 20	e ^{©at} 22 , 11		Location - City or T dalk, Mary	
Ball	permit. Departn Importa any injt		21. Signature of Directal Service Licen	on nell	lu	 	Name and Onnell 110 So	Address Y F	uneral Fersion	Home Of Road,	Dun	dalk,P.A. dalk,MD.2	1222
OCTV	Pnysician/ Medical Examiner		23a. Part 1. Enter the disease, or comshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		NSM	ALL C			, such as cardiac				Approximate Interval Between Onset and Death
D, E11 Eauch	e executed pian and urial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or inipiry that initiated events resulting in death) Last	b. Due to (or as a Due to (or a)		,							
Box 68760	ag ag	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pre	gnancy ify)	/			23d. Date of delive	very Day Year
5, P.O.	ires that the dea signed by the a d be detached f	d by PI	Part II. Other significant conditions of	ontributing to death b	ut not resul	lting in the ur	nderlying cau	ise give	en in Part I.			use contribute to t	the cause of death?
HO D Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. In the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Completed by								24a. Was auto perf	psy ormed?	prior to co	opsy findings available ompletion of cause of
十七0十 of Vital R	sician; The certificate rector, pag	BeC	25. Was case referred to medical					26. Plac	ce of Death (Chec		2	No 1 ☐ Yes	2 L No
of Vital	hysician; nis certific I director,	10 B	examiner? 1 Yes 2 To	Hospital:		R/Outpatien		Other	r		idence	6 ☐ Other (Specif	y)
on of	kttending Phydeath. ctor: After this y the funeral d	Certificate:	27. Maner Peath Natural 5 Pending 2 Accident Investigatio			8b. Time of injury	28c.	Injury work? 1 🔲 Y	at Yes 2 No	28d. Describe	how inju	ary occurred	
Division o	pital or Attencours after deatleral Director.		3 ☐ Suicide 6 ☐ Could not be determined			ne, farm, stre	et, factory, o	ffice		28f. Location (City or To		nd Number or Rura e)	l Route Number,
_	To the Hospital within 24 hours a To the Funeral C completed filled	Medical	(Check 2 Medical Exam	vsician: To the best of niner: On the basis of ex rse Practioner: To the	xamination a	and/or investi	gation, in my	opinion	n, death occurred a	at the time, date	and plac	e, and due to the ca	ause(s) and manner stated.
	Voit Con		29b. Signature and title of certifier						number			ate signed (Month,	Day, Year)
					TEYT			70	0285.	75	<u> </u>	NIE 19	2011
9	√		30. Name and address of person who	completed cause of de		23a) (Type, Pr		, (ZOAD.O	ITC A	an.	mo	21014
0	Stat	е	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	re	V-001	<u> </u>	0,10,0		<u>~</u>		-1017
	Registra	r	JUN 2 1 2011 Den	wa & .	back								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June ۲ĝ, 20°11 11:15 P M <u>Catherine Margaret Campbell</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 921 Days 1 □ M 2 🔀 F July 8, Maryland Director 220-03-5396 89 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Mt. Washington Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral United States 21209 6207 Elmbank Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14, Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Company Underwriter 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hanora Cunningham Walter McFadden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 240 Glenn, MI 49416 / Son David R. Campbell, Sr. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Dogation 5 Other (Specify) Journey Crematory 6/23/2011 Woodbine, Maryland 21. Sign of Funeral Service L 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ vi mon alt Cars disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ► 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗌 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 은 1 ☐ Yes 2 ► No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending iniury 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, 24 hours after death Funeral Director: A within 2 To the F

> CHNIS NO 32. Registrar's Signature State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

only one) 29b. Signature and title of certifier

701

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s).

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

 \wedge i

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

58303

29c. License number

City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Ma	ryland		rtment o tificate o				giene 2	Provide the state of the state	19626		
			Decedent's Name (First, Middle, La	st)						2. Date of Dea	-	V	3. Time of Death		
	Physicia Medic		Carmen L. Cumming	ıs						June _	19,	2011	2:05 A M		
	Examin		4a. Facility Name (if not institution, give				4b. City, Tow	n, or Loca	tion of Death			unty of Death			
			Casey House				Rockv				Montgomery				
	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last		If Under 1 You Months Da	ear If U	nder 24 Hrs. urs Min.	8. Date of Birt July 16	h Yearlor	9. Birth	nplace (State or Foreign ntry)		
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	nd now	l. I	Usual Residence of Decedent 10a. State 10b. County	T	10c. City, 7	Town or Loc	ation						10d. Inside City Limits		
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	or 28		Maryland Montgon 10e. Street and Number	ilery			10f. Zip Cod		. 1119		10g. Citizen	of What Cou	intry?		
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ဗ္ဗ	ural", I Exa	ed	3 Widowed 4 Divorced	If Yes, Give Year or Dates.			Yes ZL	No Sp	Peri	uvian	Spe	ecify: Lat	ino		
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anc	should be filed on and Mental Hyar is marked oth raumatic event.	일	· ·							Guitier		idi.			
Ž	d Me mark matic	Ò	Enrique Montoro 19a. Informant's Name/Relationship (Type Print)		10h Mailin	a Address (St			al Route Numbe		vn. State. Zio	Code)		
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e,	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		David Cummings / 20a. Method of Disposition	nusbaru	20b. Pla	ce of Dispo	sition (Name o	f	1	Date		tion - City or	Town, State		
no	age 1 ent of l nt; If its		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State			natory or other		ry 6/22	/2011	Wood	bine.	Maryland		
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of I Important: If ite any injury or of		21. Signature of Funeral Service Licer		шат	22	. Name and A	dress of	Facility	on Comi					
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	Medical		resulting in death)												
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	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Examine	Cause (Disease or iinjury that initiated events	c. Due to (or as a	conseque	nce off:	_								
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189	ertific ding se as	Ž	IF FEMALE: 23b. Was decedent preg <i>n</i> a <i>n</i> t	23c. If yes, outcome	of pregnance	су					230	d. Date of del	iverv		
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Ö	he de y the ched	Physician/Me	1	9 Unk <i>n</i> own											
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Sec.	The law ate has page 2	E								perf	ormed? 2 X No	death?	s 2 □ No		
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of	Attending Physician: The law requires that the death certificate be executed or death. ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	ate:	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of inju (Month, Day		8b. Time of injury		Injury at work?		28d. Describe	how injury o	ccurred			
ion	tendi Jeath tor: A the fu	ļij.	2 Accident Investigati 3 Suicide 6 Could not	h a	A 5 5 5 5		M		2 🗆 No	001 1	Ctroot and N	lumbarar Ou	ral Route Number,		
>	or At after of Direct in by	Certificate:	4 - Homicide determine	d 28e. Place of Inju- building, etc	:. (Specify)	ie, iarm, sir	eet, lactory, or	lice		City or To		urriber or nui	rai noute Number,		
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	e Hos e Fur e Fur	Medical	(Check 2 Medical Eval	miner: On the basis of earse Practioner: To the	xamination a	and/or inves	tigation, in my	poinion, de	eath occurred a	at the time, date	and place, ar	nd due to the o	cause(s) and manner stated.		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completed filled in by the funeral director.		29b. Signature and title of certifier		cense nun				signed (Month						
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	/		30. Name and address of person who				Print)								
<u>ر ما</u>	/		Nicole Christens	son 6001 Mu	ncast	er Mi	ll Rd.	Rock	ville,	MD 208	55				
	Sta		31. Date filed (Month, Day, Year)	/ 32. Registra	ar's Signatu	re									
	Registr	ar	DOMATION	Enera Ja.	bar	Ked									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Carolyne K. Crider June 16. \mathbf{p}_{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 18307 Paradise Cove Terrace 01ney Montgomery Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 0CT 11, Year 920 1 □ M 2 🛣 F Maryland 90 **Director** <u> 220-09-6518</u> Usual Residence of Deceden or 28a-f shov 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🕱 No MD **Baltimore** Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21228 34 Holmehurst Avenue USA or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. If Yes, Give "natural", Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygien 7 is marked other the Secretary State Hospital Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Rudo1ph Krausz Czerbuz Anna 1 and 2 should be Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurel, Maryland 20707 Kathie Hiatt, daughter 13106 Old Field Terrace injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit, Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 06/17/11 Baltimore, MD Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. Red 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Coron CANU disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to minimize a cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consequence of: sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) 1 Yes 2 No signed by the a d be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify Residence Daughter's 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury M Natural 5 Pending work?
1 Yes 2 No after death. Director: Af Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours a Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and 29d. Date signed (Month. Day, Year) D 35635 June 17, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

joseph Kaplan, M.D.

31. Date filed (Month) Day, Year)

18111 Prince Philip Dr. # 327

Olney, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ MASOM M. Cextende consolve 8 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Courrell Huspiral Ce weteninsten Couvel If Under 1 Year † If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, Year) Months Hours New York 214-30-2759 80 **Director** Usual Residence of Decedent show notified at 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits Director 28a-f 1 Tes 2 X No Mount Airy Marvland Frederick 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number ō "natural", or items 23a or Funeral 21771 **USA** 4101 Old National Pike within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced th and Mental Hygiene. 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Laurence M. Cockaday Marquerite M. Duggan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 9913 Cherry Tree Lane Silver Spring, Maryland 20901 Kathleen Smith, Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory Inc. 06/20/11 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition resulting in death) Due to (o as a consequence of): Medical Examiner Meturen Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of or Attending Physician; The law requires that the death certificate be executed for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) detached a Unknown 9 Illnknown director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No မ 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) After t Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director; 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or prestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Prestioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 7 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D37940 ho completed cause of death (Item 30. Name and address of p 23a) (Type, Print) out here Sult # 201

Registrar

DHMH 17 Rev 7/2009

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g916 6-21-11 yr State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (Firşt, Middle, Last) Physician/ Month 12:15 Medical Baltimore 4c. County of Death Town, or Location of Death Examiner HOSPICE Kitchie 9. Birthplace (State or Foreign If Under 1 Year If Under last birthday) 8. Date of Birth **Funeral** Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State Director 1 Yes 2 No *Itimore* 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral athedra 2120 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Never Married 2 Married 2 No 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: B 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) /Seconday (0-12) College (1-4 or 5+) Disabled Be Father's Name (First, Middle, Mother's Name (First, Middle, Maiden Surname) 2 ga. Informant's Name/Relationship (Type, Print) alling Address (Street and Number or Rural Route Num 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition Metror Crematory 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify, 4 Donation 31229 22. Name and Address of Facility 23a. Plvt 1 Linter me disease, or complications that caused shock or heart failure. List only one cause on each lin Immediate Cause (Final ter the disease, or complications that caused the death. Do not enter the Physician. disease or condition resulting in death) Medical Due to Examiner Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or). attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Pregnant at time of death certificate has been signed by the a rector, page 2 should be detached 1 ☐ Yes 2 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use con ribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably Records, 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed Yes 2 death2 To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director After this certificate h completed filled in by the funeral director, page 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be (26. Place of Death (Check only one) **Division of Vital** Other: 4 Nursing Home 5 Residence ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: Natural 5 Pending work' 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) death (Kem 23a) (Type State Registrar

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Dea **Examiner** Montgomer Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 XM 2 □ F M27157 1919 Yrs. Director 578-18**-**8029 Usual Residence of Decedent show . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Hatti filem 27 is marked other than "natural", or items 23a or 28a-f sho lury or other traunatic event, the Medical Examiner must be notified at Jury or other traunatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Co Funeral 20910 2015 East West Highway 12. Was Decedent Ever in U.S. Armed Forces?
1 ▼ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Am 11. Marital Status 1 Never Married 2 Married þ 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Bla 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Professional Driver 4vrs Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Agnes C. Anderson Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z. 19a, Informant's Name/Relationship (Type, Print) 4660 MLK Ave. S.W. #C915 Washington, DC Ingrid Wilson/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City o permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Memorial Park 6/20/201 4 ☐ Donation 5 ☐ Other (Specify) Harmony 22. Name and Address of Facility **Johnson** 716 Kennedy St. Washin 21. Signature of Funeral Service Listinse 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respira shock, or heart failure. List only one cause on each line. Immediate Cause (Final Coronary Artery Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) requires that the death certificate be executed physician and the burial-transit Cause (Disease or linjury Alzheimers Disease that initiated events resulting in death) Last Ж Due to (or as a consequence of) Physician/Medical Box 68760 e attending pny 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death g Unknown 9 Unknown ned by tl P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e þ History of Sepsis Records, Completed Dysohasia 24a The law spital or Attending Physician: Thours after death.
Ineral Director: After this certificat
d filled in by the funeral director, p **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Hospital Other: 1 Yes 2 X No 4 X Nursing Home 5 ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Des Certificate: (Month, Day, Year) injury 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and du 29b. Signature and title of certifier 29c. License number R096053MDCRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #130

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3. Time of Death	
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10d. Inside City Limits 1 X Yes 2 \(\square\) No	
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Approximate Interval Between Onset and Death 10Years	
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1 △ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Harmony Memorial Park 6/20/20	ll Landover, MD
21. Signature of Funeral Service Listing	22. Name and Address of Facility Johnso 716 Kennedy St. Washi	n & Jenkins Funeral Home ngton, DC 20011
23a. Part 1. Enter the disease, or communication shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. Do not enter the mode of dying, such as cardiac or response cause on each line. a. Coronary Artery Disease Due to (or as a consequence of):	iratory arrest, Approximate Interval Between Onset and Death 10Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Congestive Heart Failure Due to (or as a consequence of): c. Alzheimers Disease Due to (or as a consequence of): d.	5Years 5Years
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions c	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
History of	Sepsis	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown
Dysohasia		24a, Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🔊 No 24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical examiner?	26. Place of Death (Check only	one)
1 Yes 2 X No		5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1	(Month, Day, Year) injury work? M 1 \(\text{Yes} 2 \) No	Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office 28f. L	ocation (Street and Number or Rural Route Number, ity or Town, State)
(Check 2 Medical Exam	sician: To the best of my knowledge, death occured at the time, date and place, and due iner: On the basis of examination and/or investigation, in my opinion, death occurred at the ti se Practioner: To the best of my knowledge, death occurred at the time, date and place, and	me, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier	29c. License number R096053MDCRNP	29d. Date signed (Month, Day, Year) 6/20/2011
30. Name and address of person who Babette Pennay, C	completed cause of death (Item 23a) (Type, Print) #130 .R.N.P 15245 Shady Grove Rd. Rockville,	MD 20850
31. Date filed (Month, Day, Year) JUN 2 1 2011	32. Registrar's Signature	
	ORIGINAL	

State

Registrar

11-04519 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Anne Clingenpeel State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Anne Whitenak Clingenpeel 2. Date of Death Physician/ Month Anne Whitenak Clingenseal Medical Examiner 1102 hrs June 16, 2011 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Franklin Square Hospital Rosedale **Baltimore County** 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign Country) VA Min Months Days Hours Director 01/23/1930 223-30-5214 1 M 2**X**F Usual Residence of Decedent lay. 10a State 10b. Count Oc. City, Town or Location 10d. Inside City Limits Waldorf MD Charles 1 Yes 2 No s 23a or 28a-f show e notified at once. 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other tranmatic event, the Medical Examiner must be notified at once. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2306 Pinefield Rd. 20601 Funeral 11, Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married Yes White 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Giva Year Specify: Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Maryland Book Baltimore, MD 21215-0036 Book Keeper 2 Exchange 17. Father's Name (First, Middle, Lest 18.Mother's Name (First, Middle, Maiden Surname Be Margaret Theon Warden James William Clayton 19a. Informant's Name/Relationship (Type, Print) aughter Deborah Anne Whitenak Hayes/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) University Park, MD 20782

Date | 20c. Location - City or Town, State <u>4322 Van Buren St.</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 Cremation 3 Removal from State crematory or other place) June 18, Beltsville, MD Chesapeake Crem. 2011 Donation 5 Other Specify: 22. Name and Address of Facility FA/Stephen D. Lohrmann P.A. 21 Signature of Funeral Service Licens Pastures Dr. Baltimore, MD Green Physician Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last e attending physician and for use as the burial - transit ician/Medical X AMENDED Item# 1, per me, g916 6-27-11 sm UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Physi 1 Yes 2 No 9 Unknown 9 Unknown signed by the Pert II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 ✓ No 3 Probably 4 Unknown Diabetes Mellitus; Asthma Completed Auter this certificate has been funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy performed? death? ✓ Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 P ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 ✓ Yes 2 No 28a. Date of Injury (Month, Day, Yaar 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural Pending 1 Yes 2 No hours after death. To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. gnature and title of certifier 29c. License number O.C.M.E. June 17, 2011 30. Name and address of person who completed cause of death (Item 23a)

State 31. Date filed (Month, Day, Year)
Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

OCME 2006

Laron Locke MD.

32. Regis rar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:45 AM 06/20 Bettie Lillian 12011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE, GOOD SAMARITAN HOSPITAL 8. Date of Birth (Month, Day, Aug • 21 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** ^{Year)}19<u>23</u> 1 M 2 X F Days Hours Min. Months Ohio 87 295-18-9547 Aug. **Director** Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Towson MD. 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 21286 USA 1103 Ivywood Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give ģ 1 Never Married 2 Married 1 ☐ Yes 2x No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeping Bookkeeper Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Emily App Paul Couch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce, 1403 Autumn Leaf Rd. Towson, MD. 21286 Marsha E. Simmons/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 6-23-11 Timonium, MD. Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Son, Funeral Home, 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CARDIOGENIC Medical Due to (or as a consequence of Examiner DAYS Sequentially list conditions, if any, leading to immediate cause. Enter oncorping Cause (Disease or iinjury Examine Due to (or as a consequence of): C. difficle attending physician and for use as the burial-transit infection that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Pregnant at time of death Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown ESRD (ON HEMODIALYSIS), HTN ANEMIA Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIVERTICULOSIS autopsy 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 2 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28d. Describe how injury occurred Natural iniury 5 Pendina , after death. I Director: Aft ✓ in by the fu 2 Accident
3 Suicide Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Conflying Nurse Practioner: It is conficted by including death commendent the films of the cause of the films of the cause of the films of the cause of the cause of the films of the films of the cause of the films of the cause of the films of the cause of the cause of the cause of the films of the cause of the cau (Check الله within ك خ **the F** rily one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06/20/2011 RES 000 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar SRITIKA

31. Date filed (Month, and ear)

THAPA

BALTIMORE

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗍 Certificate of Death 2 Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) **Physician** 2011 eon June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Baltimore Future Care Nursing Home If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days Hours Months 12M 2□F March23,1936 Md 216-32-8903 75 Director Usual Residence of Decedent 10d. Inside City Limits 10c City Town or Location 10a. State 10b County or items 23a or 28s-f show the Medical Examiner must be notified at 1 XYes 2 No n/a Baltimore Md Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 431 Notre Dame Lane death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or item eny Injury or other traumatic evant, the Madical Essential Once. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 Yes 2N No Baltimore, Maryland 21215-0036 Specify Specify: Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Custodian Private School unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annable McCorkle 2 Hampton Cloude 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1613 E. Madison St. Apt3 Balto. Md 21205 e of Disposition (Name of Date 20c. Location City or Town, State Alberta Raynor/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State June24,2011Baltimore,MD 4 ☐ Donation 5 ☐ Other (Specify) Trinity Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. 21213 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Day Month in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 DNo 24a. Was an 200 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Decritiving Physician: To the best of my knowledge death occurred at the time. Jate and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Dat signed (Month, Day, Year) 29b. Signatule and title of certifier leted cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death County of Death Examiner Jarrettsville Harford Madonna Heritage Birthplace (State or Foreign Country) 8. Date of Birth 9. Birthplace (Star (Month, Day, Year) April 25,1919 Maryland Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** Davs Hours 1 🗆 M 2 😿 F 219-07-8087 Director 92 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental للمستمدة Director 1 Yes 2 XNo Jarrettsville Harford MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21084 3982 Norrisville Road ural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 Yes 2 No Specify Yes Give "natural". 3 🖵 Widowed 4 🗌 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Havre de Grace 27 is marked other than traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) ment of Health and Mental Hygiene. ant; If item 27 is marked other tha Elementary School Reading Aide 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ဂ William G. Gerting Geneva Zeitler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 6534 Autumn Crest Lane-Hoschton, Georgia 30548 Jean Grossman-daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cometery, crematory or other place)
Evans Funeral Chapel and
Cremation Ser Belair 1 Burial 2 Cremation 3 Removal from State 106/20/2011 Forest Hill, Maryland Important any injury o 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility Evans Funeral Chapel and 3 Newport Drive-Forest Newport Drive-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate terval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions. Due to (or as a consequence or) cause (Disease or linjury use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical phy attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 _ Ectopic pregnancy in the past 12 months? Month for Day 5 Other (specify) Pregnant at time of death been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has, page 2 s performed 2 No Yes 2 certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 000 ျှ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Tes 2 🗌 No

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 funeral After n 24 hours after death.

Funeral Director: A pleted filled in by the fu within 2 To the I 0

State

Medical

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Suicide

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29a. Certifier

(Check

only one

29b. Signature and title of

Investigation

determined

Could not be

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3 L

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Day **Physician** 12:20 PM Chaplinski 2011 Edward JUNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE SQUARE ROSEDALE FRANKLIN HOSPITAL 8. Date of Birth (Month, Day, January 9, Birthplace (State or Foreign Country) . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** Days Months Hours 1**X** M 2 □ F 67 212-42-6327 Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ns 23a or 28a-f shov 1 ☐ Yes 2 ☐ XNo Director Dundalk Maryland Baltimore 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number USA 21222 1046 Old North Point Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ortant: If item 27 Is marked other than "natural", or iter Injury or other traumatic event, the Medical Examinar 1 and 2 should be filed within 72 hours atter of Health and Mental Hygiene. em 27 Is marked other than "natural". or itea 1 □**X**es 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify Specify: White ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Vending Company 10 years Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Unknown Unknown ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9322 Sea Point Road, Edgemere, Maryland 21219 Stepdaughter Valli Delair permit. Pages 1 am Department of Heal Important: If item 2 any Injury or other once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June 21, 1 ☐ Buriat 2 ☐ X remation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory 2011 4 Donation 5 Dother (Specify) Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Luci Sequentially list conditions, if any, learning to infine relate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dire to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. physician Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an perform 1 ☐Yes 2 ☐No 2 No 1 ☐Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 210H 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes Certification: To . Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident completely filled in by the 6 ☐ Could not be 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide t 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I the

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2 1 2011

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kontanalo

32. Registrar's Signature

backe

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29c. License number

D0070076

29d. Date signed (Month, Day, Year)

welthon woods Rd, Party 4, mp. 4234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** PM 418 Daniel G. Dugas 7 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Baltimore 5+ AGNES
5. Social Secution Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Oct. 2 1 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 □ F 56 Oct. Director 213-62-8657 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, If a 1-5 fical Examiner must be contacted. 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1243 Greystone Rd. 21227 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. 2 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineer Electrical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clement V. Dugas Corinne E. Cox ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Dugas 1243 Greystone Rd., Arbutus, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory LLC 6/21/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of F mal Service Licensee 22. Name and Address of Facility Amorose Funeral Home Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Anoxic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed Acute Kidne the attending physician and hed for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Pe certificale 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 No To the Hospikal or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifics 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Gatheana 17 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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Year)

31. Date filed (Month, Day,

Baltimore

21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Horace Douglas 05:20HM 06 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hosp Baltimore SPE CIAlty University If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours 1 M 2 F 215-07-7109 94 06/21/1916 Director Virginia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at Yes 2 No Director MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? If item 27 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be r 905 Timberland Ct. 21225 Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23s U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Be Completed by Specify 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 6th Grade College (1-4or 5+) Auto Mechanic Pasadena VW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unk ၉ Unk 19a. Informant's Name/Relationship (Type. Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 905 Timberland Ct., Baltimore, MD 21225 Sandra Blizzard-Dorsey Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State On-site Crematory 06/19/11 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Joseph Achess BrownJr. Funeral Home Jan 2140 N. Fulton Ave., Baltimore, 21. Signature of Funeral Service Licenses MD21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Workis /Medical Due to (or as a consequence of): Examiner vere Deri Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed nemio and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ss of person who completed cause of death (Item 23a) (Type, Print) Charles Muluacta 5.

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State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Registrar's Signature

ORIGINAL

601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 7:58 A^{M} June 14 Davis Donald Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Buckingham's Choice Adamstown 5. Social Security Number 6. Sex 1 🔼 M 2 □ F If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** October 24, 1930 Washington, D.C. Months Days Hours Director 578-36-9330 80 Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location the Maryland 1 Yes 2X No Adamstown Frederick Maryland ۵ 10f. Zip Code 10g. Citizen of What Country? ò 10e. Street and Number ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral United States 21710 7000 Upland Ridge Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?,
1 Yes 2 No Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit, Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Many injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) Newspaper Machinist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Raznick Ida Hugh Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7000 Upland Ridge Drive, Adamstown, Maryland 21710 <u>Carol M. Davi</u>s / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June Date 17, cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc 2011 21. Signature of Funeral Service Licensee Robbert Addre Full Fallirey Funeral Home/Rockville, 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 the 1 4.4h M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transi Lause (Lisease or linjury attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Other (specify) Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>S</u> Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law In 24 hours after death.

the Funeral Director: After this certificate has be page 2 s autopsy 1 Yes 2 X No 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner?
1 Yes 2 X No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred X Natural injury 5 Pending 2 🗆 No Investigation ☐ Acciden ☐ Suicide Accident completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) June 14, 2011 D0058726

DHMH 17 Rev 7/2009

State Registrar

Yvette Lopez-Warren, M.D. 3000D Ventrie Court, Myersville, Maryland 21773

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

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		Examin				n, give street and num neral Ho		21	4b.	City, Town, or Berli		n of Death			County of		
		Funeral		5. Social Security N	lumber	6. Sex		yrs, last birth	day) If I	Jnder 1 Year	If Unde	er 24 Hrs.	8. Date of Bi	irth	Worc	9. Birthp	place (State or Foreign
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		aryland ia-f show	Director	10a. State MD	10b. County	rcester	10	c. City, Town	or Location	lity						1	0d. Inside City Limits
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		ath wit	Funeral	UNK 11. Marital Status		12. Was Dec	edent Ever	in U.S	13 Was [2184		ngin? (Spe	ecify Yes or No	- 1	USA 14. Race	Americ	an Indian
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	land	l be filed v fental Hyg rked othe tic event,	To Be	17. Father's Name ((First, Middle, ald D	Last) ionne	_				18. Mot		e (First, Middle elma I			ing	
35	Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mentall Hygiene. Department of Heath and Mentall Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na Thelma			ther						al Route Numb				
D 03	more	Page 1 an nent of He int: If iten iny or oth		20a. Method of Dis 1 ☐ Burial 2 ⁴ 4 ☐ Donation	Cremation	3 ☐ Removal from Specify)	State	20b. Place of Atam	Disposition Cremator	(Name of Crem	e)		Date 14/11				wn, State ie MD
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417/2011	_ p	hysician/		shock, or hea Immediate Cause	ırt failure. List (Final	r complications that only one cause on ea	ach line.	Hypert	ensiv	mode of dying	g, such a	s cardiac o		ırrest,	٠٠.		Approximate Interval Between Onset and Death
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125/19	09/89	ng phy as the	Med	IF FEMALE:													
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month 804 PM **Physician** Jacqueline Mary June 17 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5+ Agnes
5. Social Security Number Baitimore Hospita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 7/21/1926 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M XXF Months 84 220-18-9944 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic event, the Medical Evandaric rust be notified at 1 ☐ Yes 2 XXIXIo Director Anne Arundel Linthicum MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21090 items 23a Funeral 122 Patricia Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 9 1 ☐Yes XX No Specify Specify: White þ XX Widowed 4 □ Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mantal Hygiene. Important: If item 27 is marked other than any injury or other traumatic access. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sara Houck ဥ John Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 122 Patricia Ave Linthicum, MD 21090 Mr. Joseph Dyer / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Veterans-Crownsville 6/21/2011 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature / Funeral S Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 M01220 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Days Pneumoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine P.O. Box 68760,52 burial-transi Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) is certificate has been signed by the director, page 2 should be detached 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Stroke Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 XNo 1 ☐Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 1 Inpatient 2 ER/Outpatient 3 DDA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred of or Attending Parter death. 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide To the Hospital of within 24 hours at To the Funeral D 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P23490 Gattre Cure 17 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON AVENUE BALTIMORE MD 5 900 EVELYN GATHECHA

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)
JUN 2 1 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) D2011 6:10p M JUNE 18. Physician/ MAMMIE LEE DAVIS Medical 4b. City, Town, or Location of Death 4c County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BALTIMORE TOWSON GILCHRIST HOSPICE CARE 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 251-58-1712 Funeral Min. (Month, Day, Yea 5-2-1933 Davs Hours Months SOUTH CAROLINA 1 □ M 2 🛣 F 78 Director Usual Residence of Decedent 10d. Inside City Limits 3a or 28a-f show t be notified at 10c. City, Town or Location 10b. County 10a. State Director 1 √ Yes 2 □ No OWINGS MILLS BALTIMORE MD. 10g. Citizen of What Country? 10f. Zin Code 10e, Street and Number ms 23a must be Funeral USA 21117 5 KIMBERLY ANN CT. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) ed other than "natural", or items event, the Medical Examiner mu 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces 2 X No 0 Completed by 1 Never Married 2 Married BLACK within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: Maryland 21215-0036 If Yes, Give Year or Dates. 3XXWidowed 4 ☐ Divorced 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) RALEIGHS CLOTHING_CO. SEAMSTRESS -0--12-18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ JESSIE BENJAMIN JACK BENJAMIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5 KIMBERLY ANN CT. OWINGS MILLS, MARYLAND 21117 Health a SAMUEL DAVIS(SON) Department of Healt Important: If item 2 any injury or other 1 once. 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Page 1 1 X Burial 2 Cre nation 3 Removal from State BALTIMORE, MARYLAND 6-22-2011 KING MEMORIAL PARK 4 Donation 5 Other (Specify) HIBNER2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. of Funeral Service Licensee <u>IONATHAN</u> 21. Signatu 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition ZND STAGE Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Cause (Disease or iinjury that initiated events the burial-tran Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Year in the past 12 months
1 Ves 2 No Month Pregnant at time of death signed by the aid be detached for 1 Yes 2 L P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? Colitals 24a. Was an autopsy performed? 1 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? completed filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 28b. Time of 28c. Injury at 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: work? 1 Watural 5 Pending Accident M Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29d. Date signed (Mgnth, Day, Year) 29c. License number 29b. Signature and the of cert 71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 21206 SUTTE 4105 STREET KUHAR NO CHARLES 701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 1 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4:40 PM Month June 19, 2011 Physician/ Eleanor M Eubank Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Lutheran Village Westminster 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Days Min. 1 □ M 2 X F Hours 97 Months (Month, Day Year) North Carolin 1914 Director 238-01-3378 Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10b. County with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No Carroll Westminster 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number by Funeral United States 21158 200 Saint Luke Cir filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 72
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "I any injury or other traumatic event, the Mexiconce. College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lowing Katherine Herbert Dennis McCoy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 236 Hitching Post Dr. Bel Air, MD 21014 Pleines /Daughter Charlotte 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Jun 21 cemetery, crematory or other place) 1 Burial 2 N Cremation 3 Removal from State Beltsville, Maryland 2011 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation and Funeral Alternatives 21. Signature of Funeral Service License 8717 Green Pastures Drive Towson Maryland 21286 Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner ornon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine pue to for as a consequence of: that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Pregnant at time of death Unknown s been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed Chrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s performed 1 Yes 2 No Yes 2 No this certificate 25. Was case referred to medical examiner? of Vital director, Be 26. Place of Death (Check only one) Hospital Other: 2 🗆 No 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Division 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Inglical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ MARIE ELIZABETH ERNST :00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tizens D (700 ursin Security Number If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** AUG. 21, 1 M 2 X F 91 Months Hours Min. 220-01-5396 Days 1919 MD Director Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director HARFORD BEL AIR MD. 1 🗆 Yes 2 🛣 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō 21014 Funeral items 23a 1408 MIDHURST CT. UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after WHITE 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural", 3 Widowed 4 Tovorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry than Elementary/Seconday (0-12) College (1-4 or 5+) FOOD MANUFACTURER should be filed within and Mental Hygiens 7 is marked other th MEAT PACKER 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ JOHN THURNHUBER CATHERINE DIEM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau SHIRLEY BROOKS/DAUGHTER 1408 MIDHURST CT. BEL AIR, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State HOLY REDEEMER CEM. 6/23/2011 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Fune al Service License 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Fig. 1) disease or condition resulting in death) Physician/ Jements 1 Medical Due to (or as a consequence of): Examiner Presmothery Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examir Cause (Disease or linjury that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) burial Medical Box 68760 attending phys IF FEMALE: Physician/ 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown been signed by the sahould be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has to page 2 s autopsy perform death? certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? director. Be Division of Vital 26. Place of Death (Check only one) 2 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) the Funeral Director: After this mpleted filled in by the funeral di 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate; the Hospital or Attending thin 24 hours after death. Natural injury work? 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ٩ 2 M. 1 20/11 41m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11V)6 an US 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year FOG art 0-616 0925 AM 00 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Julia Marior Health Habenestown Jashington are If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1) Year 929 1 🗆 M 2 🔀 F Days Hours Min Kentucky Director 82 Yrs Apr 402-36-2198 Usual Residence of Decedent 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 X Yes 2 No Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? 1909 Grinnalds Avenue 21230 United States permit. Page 1 and 2 should be filed within 72 hours after death w. Department of Health and Mental Hygiene. Important: If item 27 is marked other them any injury or other traumer. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify If Yes, Give 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Mattie Taylor Augustus Sexton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina C. Conway / Daughter 1909 Grinnalds Ave Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 6/22/2011 Woodbine, Maryland Signaturof Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the risc ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Transitiona Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 1611 abetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): burial-transit pertensio that initiated events resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Tetal death in the past 12 months?

1 Yes 2 No signed by the atter Day Month Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Steoporosi's, Anemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown has been sign 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Acute Renal To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 🔀 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🔀 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No M Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) hava Mades 125 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -333 MillStReet, Harpinsta Durbara Nadew

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State Registrar 31. Date filed (Month, Day, Year)

2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2011 **Physician** 8:15 15 Robert Franklin /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agnes HOSPITCI Baltimore 1 Year | If Under 24 H Date of Birth (Month, Day, Year) 11-19-42 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1√ M 2 □ F Months Days Hours 217-38-1640 68 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at XYes 2 □ No Director MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Apt. #506 ö USA 23a Walbrook Avenue 21216 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. African Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 3altimore, Maryland 21215-0036 ō 1 □Yes 2 No Specify: þ Specify:American 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Car Wash 6th Grade <u>Attendant</u> permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other I any injury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pau1 Wilson Virginia Chew ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Davis-Sister 6022 Barstow Road Rosedale Road 21206 Eva 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State OnSite Cremation: Baltimore, MD 06-18-11 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 638 N. Gilmore Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PNIUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner INFECTION URINE physician and s the burial-trans Due to (or as a consequence of): attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Q I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, HEART 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has , page 2 certificate 2.E.No 1 ☐ Yes 2 ☑ No 1 ☐ Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Hospital or Attending 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the Funeral Direc. 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) within 2. and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DU051865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 57. HGNES /1050/TML, CHARLES BALTIMORE, MO CURTIS mo 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Allen 2011 Donald Fales Sr. June 19 4:40 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1000 Norwich Court Abingdon Harford 9. Birthplace (State or Foreign Country) 929 Mary Land If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Days 1 🔀 M 2 🗆 F 215-24-3438 81 Director Sep. Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoi ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland | Harford Abinadon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1000 Norwich Court 21009 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give 3 X Widowed 4 Divorced White Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Appliance 8 Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ May Regina Jirsa William George Fales 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Robin Street / Daughter 1000 Norwich Ct., Abingdon, Maryland 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park 6-22-2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ungestick disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death in the past 12 months? Month Day Year Yes 2 No the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Hunknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 10 Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 🗌 No Accident Suicide Investigation after death the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3445E 32. Registra State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Joseph C. Farrell June 2011 9:15 P 16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6237 Fernway Road Baltimore n/a 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1X M 2 D F Days Months Hours Min Mary land Director 216-28-8885 Ĩ932 78 Usual Residence of Decedent or 28a-f show notified at 10b. County death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD 6237 Fernway Road 1 X Yes 2 No n/a 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be r Funeral 6237 Fernway Rd. 21212 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes 2 If Yes, Give Year or Dates. permit. Page 1 and 2 should be filed within 72 hours after of Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Systems Analyst Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Farrel1 Anita Clautice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Farrell/wife 6237 Fernway Rd., Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Benation 5 Other (Specify) Mary's Cemetery 6/21/11 Baltimore, Maryland h W. Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Inc. Bryan 23a. Part 1 Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ esur disease or condition Medical resulting in death) Due to (or is a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the hurial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No ER/Outpatient 3 DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No within 24 hours after death

To the Funeral Director; /
completed filled in by the f Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatur 29c. License numbe 29d, Date signed (Month, Day, Year) D20649 mil

State Registrar 32. Registrar's Signature

1734 York Rd., Lutherville, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Bowie, M.D.

JIIN 21

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Fitzsimmons Anna Mary 06 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X Months Min (Month, Day, Year) 08/26/1917 93 Director 218-09-6438 Italy Usual Residence of Decedent 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at irector 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Millersville 1 Yes 2 X No ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 792 Springdale Drive 21108 U.S.A. itzsimmens, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 □ Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Giordano Papa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Loretta Perozzi / Daughter 776 Martin Court Severn, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State 106/18/2011 4 Donation 5 Other (Specify) Our Lady of Fields Millersville, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death vennou Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year signed by the a 1 Yes 2 L g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After 1 Natural 5 Pending Accident
Suicide 1 🗌 Yes 2 🗌 No Investigation the 24 hours after deatl Funeral Director: 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined ical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie りいろそひ 06/16/ work 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

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32. Registrar's Sign

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ 2:07 A.M Hugh A. Fishpaw June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Parkton 17618 Pretty Boy Dam Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🔀 M 2 🗆 F Months (Month, Day, Year Feb. 17. Hours Director 82 Yrs. Maryland 214-26-0035 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director Baltimore Parkton Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code United States of America Funeral 21120 17618 Pretty Boy Dam Road permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 K No Specify. If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) Budget Office Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward Fishpaw Luella Virginia Painters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Gwendolyn A. Fishpaw/wife 17618 Pretty Boy Dam Road Parkton, Maryland 21120 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June Date 18, Evans Funeral (1) ther place) Chapel Bel Air 5 1 Burial 2 X Cremation 3 Removal from State injury 4 Donation 5 Other (Specify) 2011 Forest Hill, Maryland 21. Signature of Fuy ral Service Licensee any in Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timorium, Maryland 21093 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or I that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ODYSPLASTIC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🔲 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural work? 5 Pending 2 🗆 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addy cause of death (Item 23a) (Type, Print) MMONIUM MD ZW93 MLANEY JUN 21

DHMH 17 Rev 7/2009

Registrar

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State Amend Items 25 per me, g916,06720720 Philip Health and Mental Hygiene 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **JACOB** GOLDENBERG 4:36 AM June Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE N/A 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) ROMANIA Months Days Min. Hours 0471471921 **Director** 547-78-8032 90 Usual Residence of Decedent 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6203 WALLIS AVENUE VENEZUELA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married Black, White, etc. 1 Yes 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) ADMINISTRATOR **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental H ဂ JOSEF GOLDENBERG **BERTA** SCHNEIDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau MICHELLE GOLDENBERG/WIFE 6203 WALLIS AVENUE, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) AGUDATH ISRAEL CEM 06/05/2011 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death Immediate Cause (Final Ph sician/ hemow have intracranial Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading transcribed cause. Enter Underlying Cause (Disease or linjury Due to libras a nonsequence of Exami Physician: The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) Month Year 2 No ate has been signed by the page 2 should be detached g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' Yes 2 No 1 🗌 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 217 Hospital Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending iniury work? Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 1 Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 5th 2011 AT - 24389 46 - B5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

UNIVERSITY

egistrar's Signature

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31. Date filed (Month, Day, Year)

PKWY

, BALTIMORE, MD

State Registrar

address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certification

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 201<u>1</u> Gertrude Ρ. Goedeke 19 4:31 P ^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Cockeysville Broadmead Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 X F Mary land 3/7/192 216-18-7293 **Director** 90 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Cockeysville Maryland | Baltimore 1 🗆 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13801 York Road Rm 204 21030 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 X XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 🙀 Widowed 4 🗆 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be Important of Health and Mental Hy, Important if item 27 is marked other any injury or other the second of the seco 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William F. Knell Gertrude Karfgin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4111 Cremson Drive Phoenix, Maryland 21131 Eric W. Goedeke / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkwood Cemetery 6/22/2011 Baltimore, Maryland ^{22. Name and Address of Facility} Ruck Towson Funeral Home, Inc 1050 York Road Towson, Maryland 21204 elle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due * (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to in nedicause. Enter Underlying Directo (or as a consequence of) Cause (Disease or linjury siclan and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Month Pregnant at time of death ate has been signed by the a page 2 should be detached a 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by TENSION 1 Yes 2 No 3 Probably 4 Unknown FORAMEN OVALE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 🗆 Yes 2 🗆 No 1 ☐ Yes 2 🗗 To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (ck only one) examiner? Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Avursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after deat...

To the Funeral Director: After completed filled in by the fu 2 Accident
3 Suicide Investigation Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 🚣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar

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Physician
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Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment the crotified in once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	for State Registrar	otate of Mary	(Certificate of	Death		Reg. No	UII	1965		
ian	1. Decedent's Name (First, Middle, Last)					2. Date of Dea		_ Year	3. Time of Death		
cal	Margaret J. Gentl					June	16 ^{ay}	2011	6:30 P	M	
ner	4a. Facility Name (If not institution, give stre	eet and number)			Location of Death	1		4c. County of Death			
	Fairland Center 5. Social Security Number 6. Sex	7 Age (In	yrs. last birth	Silver S	DELLIS I If Under 24 Hrs.	8 Date of Birt		ontgome	L'y place (State or Fore	eian	
				rs. Months Days	Hours Min.	8. Date of Bird Oct. 2a	1929) Mary			
	Usual Residence of Decedent										
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ecto	Maryland Prince Ge	eorge's F	lyatts						1 □ Yes 2√	INO	
Be Completed by Funeral Director	10e. Street and Number 2900 Jamestowne Roa	nd.		10f. Zip Code 20 7 8	2			n of What Cou . S • A •	ntry'?		
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ပိ	17. Father's Name (First, Middle, Last)		1.10	anager	18. Mother's Nam	o (Firet Middle					
Be	Grayson Ford				Naomi E			arrianio)			
ဍ	19a. Informant's Name/Relationship (Type.	Print)	19b. f	Mailing Address (Street				own. State. Zi	n Code)		
	Colleen Gentle / Da		- 1	Far Corner					1152		
	20a. Method of Disposition	20	b. Place of E	Disposition (Name of crematory or other place	20)	Date	20c. Loca	tion - City or T	own, State		
	1 X Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)			ove Cemetery	6/21,	/2011	Mt. A	Airy, M	aryland		
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral										
	1///			1050 York	Road To	wson, Ma	arylar	nd 212	04		
	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of	In ns that caused the d	eath. Do no	ot enter the mode of dyin	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death		
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P.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
Ē	Sequentially list conditions, if any, leading to immediate dates. Extra Underthing Cause (Disease or injury that initiated events c	250 6 (4. 46 4.05.165425.165 4./).						-			
Exa	resulting in death) Last	Due to (or as a con-	sequence of):							
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an/	23c. Was decedent pregnant in the past 12 months?	. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etal death	3 ☐ Ectopic pregnanc	у		23	d. Date of deli	very Day Year		
sic	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	of death	5 ☐ Other (specify) _				17.07.111			
H.	Part II. Other significant conditions contrib	buting to death but not	resulting in t	the underlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to	the cause of death'	?	
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še C	25. Was case referred to medical				26. Place of Dea	1		1 1165	2 🗆 100		
70 E	examiner? 1 ☐ Yes 2 🙀 No	pital: 1 ☐ Inpatient 2	⊇ ☐ ER/Outp	oatient 3 DOA Oth	er: 4🎾 Nursing H	ome 5 ☐ Resi	dence 6	Other (Spec	ify)		
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Sta Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death 17^{Pay} Physician/ Gillcrist Marcia Hammond June 2011 11:25 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Hospice Casey House Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, g. Birthplace (State or Foreign **Funeral** Hours Days 1 M 2 X 126-26-1231 Illinois 79 November 12, 1931 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Marvland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9510 Edgeley Road 20814 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 X No Specify: "natural", Completed 3 K Widowed 4 □ Divorced White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " United States Elementary/Seconday (0-12) College (1-4 or 5+) Government Medical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental F ပ Page 1 and 2 should be Jabez Dean Hammond Marcia Prendergast and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Patricia G. Porter / Daughter 5804 Melvern Drive, Bethesda, Maryland 20817 other Date 22, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) June 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2011 Silver Spring, Maryland 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Litter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Physician/ Alzheimer's Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Due to for as a consequence on Exami burial-transif Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last sician Physician/Medical phys the b Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) Year Pregnant at time of death 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 should be Urinary Tract Infection 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law this certificate has page performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 🔀 No Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) Hopsice 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 | Pending М Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🛛 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b, Signature and title of certifier

31. Date filed (Month, Day, Year)

Nicole Christenson,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

5

29c. License number

R120698

6001 Muncaster Mill Road, Rockville, Maryland 20855

29d. Date signed (Month, Day, Year,

June 18, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 MILDRED GREENBERG JUNE 2:03 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SLADE AVENUE #503 BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 🔭 F (Month, Day, Year NOV . 24 . 1 Months Country) Director Usual Residence of Decedent 28a-f shov 10a State with the Maryland 10b. County 10c. City, Town or Location Examiner must be notified at Funeral Director 10d. Inside City Limits BALTIMORE MD 1 Tes 2 XXVo BALTIMORE ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a 1 SLADE AVENUE **#503** 21208 USA Page 1 and 2 should be filed within 72 hours after death whent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. "natural", or þ 1 Never Married 2 Married ☐ Yes 2 **XX**No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 ▼Vidowed 4 □ Divorced Specify Year or Dates WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed, other than Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evonce. ၉ MAX RUBIN ANNA BERLIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERNARD RUBIN / BROTHER 11 SLADE AVE, #911; BALTIMORE, MD 21208 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Murial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) EBREW YOUNG MENS 6/19/2011 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Math 8900 REISTERSTOWN RD; BALTIMORE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence Exami tran and that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician the burial Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year the a detached Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 Director: After this certificate has performed No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita Other: 1 Tyes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending after death. Accident
Suicide
Homicide 1 Tes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined hours Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 24 (Check within 2 To the F only one 29b. Signature le of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of

ersor

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1813 2011 Physician/ June Baby Boy Hayes Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number **Examiner** Baltimose C The Johns Hopkins Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number Month, Day, Year 2011 Maryland **Funeral** 1 🕅 M 2 🗆 F June Director infant Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10h County Director 1 X Yes 2 No Brooklyn MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe USA Funeral 21225 205 W. Meadow Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. within 72 hours after death 11. Marital Status Black, White, etc. Armed Forces? δ 1 Never Married 2 Married black 1 ☐ Yes 2 X No Specify. Specify. Maryland 21215-0036 If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) infant infant infant infant unk 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Dasha Hayes 1 and 2 should be find Health and Mental item 27 is marked ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 601 N. Wolfe Street Baltimore, MD The Johns Hopkins Hospital or other Saltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of H Important: If ite any injury or oth once. ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 💢 Other (Specify) in ട്ടുണ്ട and Address Mysacits bard 655 W. Baltimore Street Signature of Euneral Service permit. 21201 Baltimore, MD 23a. Part . Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate s (Final disease or contion resulting in death) Extreme PreMaturit Physician/ Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or liniury physician and the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) 23b. Was decedent pregnant Year Month Day in the past 12 months? 1 Yes 2 No Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy /performed? 1 🗌 Yes 2 No

Hospital or Attending Physician: The law requires that the death certificate be Box 68760 P.O. Division of Vital Records, I Director: After to in by the funeral

l	25. Was case referred to medical	26. Place of Death (Check only one)
١	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 1 1 Yes 2 No
	3 Suicide 6 Could not 4 Homicide determined	28e Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,

	_		the time date and due to the cause(s) and manner as stated.
00- 0	a differen	+ 57	Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29a. C	ertiller	1	Oer triying in my social to the cause (s) and manner sta
10	Check	2	Certifying Physician: To the best of my knowledge, dearn occurred at the time, date and place. and due to the cause(s) and manner stall Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stall Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stall medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stall medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stall medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stall medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stall medical Examiner:
10	JIIOUN		Medical Examiner: On the basis of examination and on investigation, in my opinion, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	nly one)	3 🗔	Certifying Nurse Practioner: 10 the best of the Newledge, death occurred at the time,
	ing onto		and Data Street Manth Day Your

	only one)	3 Certifying Nurse Practioner: To the b	best of my knowledge, death occurred at the time, date and place, and due to	the cause(s) and manner as stated.
		nd title of certifier	29c. License number	29d. Date signed (Month, Day, Ye
290.	. Signature ai	Id title of cortillo	1	

only one) 3 Certifying Nurse Practioner: To the best of my knowledge, deat	h occurred at the time, date and place, and due to	(The Cause(s) and mariner as stated.
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Vande M Form (MD	766161	June 01,2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Name and a	address of person with completed cause of doubt (nom 200) (1) person	11 2 11-1100	1 x 10 rth	hinlio stropt	7178
	carry and the Tolone Haptins	HOSDITAL WUL	NOITH	WIFE SITUE	61601
1 1000	Szymanski, The Johns Hopkins	110			
LI III	32 1. 60. 91. 1.				

State Registrar

filled in by within 24 hours after or To the Funeral Direct completed filled in by ၉

Certificate:

Medical

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 19 William Ray Hudler Jr. 2011 1:00 P Medical June 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 3233 Conowingo Road Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 26, 1 **Funeral** Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 MM 2 D Hours Months Mary Land **Director** 217-46-1350 64 1947 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21154 USA 3233 Conowingo Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married X Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give 3 Divorced 4 Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u> Heavy Equipment Operator</u> Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Ray Hudler Sr. Helen Theresa Monahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Rose / Sister 505 Maitland Street, Bel Air, Maryland 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Hilltop Service Corp. 6-20-2011 Towson, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. Kathleen antresce 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between set and Death Immediate Cause (Final Physician/ 5 MACC NON حرور disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or linjury Due to (or as a consequence of) Exami that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown s been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 has 1 ☐ Yes 2 ☐ No or Attending Physician; 25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pendina work? s after death.

I Director: Af 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Hospital Medical To the Hospi within 24 hou To the Funer completed fil 29a. Certifier 😂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 00058473 PHYSECEAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHILIP NIVATIONEN BRC AT ATNOOD ROAD, .602 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.0.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 0600 AM SVLVIA HOFFMAN Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY SUBURBAN HOSPITAL BETHESDA If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 M 2 F Days Hours Yrs Director 181-12-5970 Pennsylvania 05/14/1923 Usual Residence of Deceden 10a. State 28a-f shov 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits Director notified MD Montgomery Silver Spring 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 740 Whitaker Terrace 20901 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Specify. "natural" Completed 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the 5+ Teacher Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic o Max Schmidt Mildred Ruderman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marc Hoffman / Son 9408 Worth Ave., Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State Chesapeake Crematory 06/20/2011 Beltsville, MD 4 Donation 5 Other (Specify) Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) executed Right heart tachere and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be 68760 as 1 IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year g Unknown g Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Deigue disorder CNA Records, 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate 2 🗀 No 1 Yes 25. Was case referred to medical examiner? Vital 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospita Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this of 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After injury work? 1 ☐ Yes 2 ☐ No 5 Pending Division Accident nvestigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number D00053281 30. Name and address of d who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

ELIZABETH

31. Date filed (Month, Day, Year)

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HOSPITAL.

8600 OLD GEORGETOWN

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 9660 State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death cedent's Mame (First, Middle, Last) 2. Date of Death 3. Time of Death tonth Physician/ 2140 UNE Medical 4c. County of Death Examiner MOR If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign ge (In yrs. last birthday) **Funeral** Months Min. Yrs. **Director** 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. 10a. State 10b. County 10d. Inside City Limits Town or Location Director 1 Des 2 No me RE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 2 No ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Aather's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State gemetery, crematory or other 1 Burial 2 Cremation 3 Remo from State IMORE 4 ☐ Ponation 5 ☐ Other (Specify) Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the n shock, or heart failure. List only one cause on such line. Approximate Interval Between Immediate Cause (Final Orset and Death Ph i ian disease or condition Medical resulting in death) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use co subute to the cause of death? 6 2 0 8 ☐ Probably 4-☐ Unknown 1 Yes Completed 4b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform certificate Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 힏 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) of Certificate: 27. Manna of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: After // Natural injury 5 Pending Division Accident Investigation Suicide 6 Could not e 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) State Registrar

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118/2011

A DIVILLON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month O 6 Curtis William Herbert 201 Medical 50AM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Franklin Square
5. Social Security Number Rosedale Baltimore Hospita **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F Months Hours Min. Director 215-22-6242 Maryland 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits Md. Balto. Kingsville 1 Tes 2 V No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8 Heritage Hills Court 21087 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 'natural", or 1 Never Married 2 Married Black White etc. ģ 1 XYes 2 No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 3 Widowed 4 Divorced 1 ☐ Yes 2 ☐XNo Specify: White Completed Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Loan Officer Credit Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Herbert Nellie Hopper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 8 Heritage Hills Court Curtis J. Herbert Son Kingsville, Md. 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 s
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 A Eurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Joseph 6-22-2011 Fullerton, Md. 21. Sig at re of Funeral Ser ce Li ensee 22. Name and Address of Facility Schimunek Funeral Home Drien D 21236 9705 Belair road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Due to (or as a construence of) Artery disease or condition Disease Medical resulting in death) Examiner Pulmonary Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of: attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be-Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy 5 Other (specify) Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy death? 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 1 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Cther (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29b. Signature 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Jacanes 31. Date filed (Month, Day, Year, 32. Registrar's Signature MD 9000 Franklin Baltimore UD. 21237

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 16^{Day} Physician/ Month June 2011 3:30 David Ray Hope Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 17400 Millboro Terrace Derwood If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 ₺ M 2 🗆 F Hours West Virginia Director 233-50-2252 77 September Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17400 Millboro Terrace 20855 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 K Married 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Korea 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Law Enforcement 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည Randall Sayre Hope Helen Banister permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther A. Hope / Wife 17400 Millboro Terrace., Derwood, Maryland 20855 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park June 21, 2011 Rockville, Maryland Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home, Rockville, 300 West Montgomery Avenue., Rockville, Maryland 20850 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ IVER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) sician a Physician/Medical Box 68760 shys the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No has Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🔀 No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔀 Natural 2 🔲 Accident (Month, Day, Year) injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tipe of ce 29c. License number 29d. Date signed (Month, Day, Year) round LMD D0061083 June 17, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thambi, M.D. 9707 Medical Center Drive #300, Rockville, Maryland 20850

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Examiner 4a. Facility Name (if not institution, give street and number)							or Location of Dea	th Carry	40 Coun	ty of Death	
امتحد	Funeral		5. Social Security Number 6. Se	X 7. Age		at birthday)	If Under 1 Year Months Days			h Yearl 50		place (State or Foreign
	Director		213-48-5948 1L Usual Residence of Decedent	⊔м 2 Д г	58	Yrs.	Working Days	Tiodio Iviii	$Jan \cdot 4,$	1953	Ma	ryland
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	or 28a	Dire	Maryland Baltimon 10e. Street and Number	re	F	Baltin	nore 10f. Zip Code		T	10g. Citizen o	f What Cou	1 Yes 2 X No
	with the 23a cast be	Funeral Director	40 Bideford Court	_				21234		- C	.S.A.	
	death ritems nerm	Fun'	11. Marital Status	12. Was Decedent Ev Armed Forces?		13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		ace - Ameri ack, White	
036	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 N If Yes, Give Year or Dates.	No		1 ☐ Yes 2 🛣 No	Specify:		Speci		ite
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nd	filed v tal Hyg d othe event,	To Be	17. Father's Name (First, Middle, Last)	•				18. Mother's Na	ame (First, Middle,	Maiden Surnar	ne)	
ryla	should be file and Mental I 7 is marked o raumatic eve		Fred 19a. Informant's Name/Relationship (Type)	Mace Mace	Mor	wbray			Lillian	-	llis	
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ore,			20a. Method of Disposition 1 ☐ Burial 2 🎖 Cremation 3 ☐		20b. Pla	metery, crei	osition (Name of matory or other pla		Date	20c. Location	,	
Baltimore,	permit. Page 1 Department of Important: If it any injury or or once.		4 Donation 5 Other (Specify)	Hil		Service (Towso		aryland ome, Inc.
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ı			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	lications that caused e cause on each line.	the death.	Do not ent	er the mode of dyi	ng, such as cardia	c or respiratory arr	est,		Approximate Interval Between Onset and Death
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Division of	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At hom (Specify)	ne, farm, str	eet, factory, office		28f. Location (S City or Tow		ber or Rura	al Route Number,
id a b in the cause (s) and manner as s									ner as stat	ed.		
	the Hithin 24 the Figure 14 the Figure 15 th	Me	(Check 2 ☐ Medical Examin only one) 3 ☐ Certifying Nurse 29b. Signature and title of certifier	Practioner: To the b	est of m	knowledge,	death occurred at the	ne time, date and p	lace, and due to the	e cause(s) and r 2 <u>9d</u> . Q ate sign	nanner as s	tated.
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7)		30. Name and address of person who	mpleted cause of de	ath (Item 2	3a) (Type, I	Print) Sine	Deivo	Tows	nn II	00	1200
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ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 1 9 2011 MARIAN HAMBURG June Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Greater Baltimore Medical Cente Towson 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under **Funeral** 1 M 2 F Months Hours Min 05/06/1932 79 **Director** 219-30-4715 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2101-A WOODBOX LANE 21209 USA AMBURG, MARIAN Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ρ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 Tyes 2 X No Specify: If Yes, Give Year or Dates Specify Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWNER RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LASKY SALLY RECHENBERG LEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2101-A WOODBOX LANE, BALTIMORE, MD DAVID HAMBURG/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 06/20/2011 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEM PK REISTERSTOWN, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratory Physician/ disease or condition resulting in death) Medical Due to (or as a consequend of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial-transit MeTa and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as t the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ õ Month detached 9 Unknown 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 1 ☐ Yes 2 ☐ No Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 💢 No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, မ this (28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury accurred After Hospital or Attending work? iniury 1 Natural 5 Pending after death. Director: Aft 2 Accident
3 Suicide
4 Homicide Investigation the. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00063534

3. Time of Death

MD

10d. Inside City Limits

WHITE

1 Yes 2X No

21208

Year

Day

Greater Baltimor Medical Center, Towson, Baltimor

Approximate Interval Between Onset and Death

Α

1:05

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

h baz

Nandana

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ MontJUNE Pay, 2011 7:59 A_M STEVEN HURWITZ DAVIS Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A 4b. City, Town, or Location of Death Examiner BALTIMORE 3922 BONNER ROAD Social Security Number 8. Date of Birth Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 8/31/1958 Months Days Hours 213-58-1387 1 XX X 2 🗆 52 **Director** Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director BALTIMORE XX Yes 2 No MD N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral should be filed within 72 hours after death with 21216 USA 3922 BONNER ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. Š 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2XXNo Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: WHITE 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 DRIVER TRANSPORTATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ JOEL HURWITZ ELAINE SCHNEIDER 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau ELAINE HURWITZ / MOTHER 16 THOMAS CRADOCK CT.; BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date MIKRO KODESH-BETH ISRAEL 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/19/2011 BALTIMORE, MD 22. Name and Address of Facility e of Full eral Service SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD: BALTIMORE, MD 21208 23a. Part 1. Enter the disease, of complicati ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest se on each line. shock, or heart failure. List only one Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin physician and the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Por I in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown ed by the a detached f 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy perforn Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending injury Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined

Registrar DHMH 17 Rev 7/2009

Medical

29a. Certifier

(Check

death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 28 William Leon Johnston 2011 4:18 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sunrise Assisted Living Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Year) Months Hours 1 🔀 M 2 🗆 F 481-26-6396 82 Director Missouri March Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural", or from marked other than "natural", or other trainmatic. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Silver Spring MD Montgomery 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11621 New Hampshire Avenue 20904 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give 1946-1951 Year or Dates. Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Computers Systems Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Morgan Banks Johnston Nellie Ruth McCoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6703 Queens Chapel Rd., University Park, MD 20782 Leslie Carroll/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 28 2011 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Georgetown University 4 X Donation 5 ☐ Other (Specify) Washington, D.C. center 22. Name and Address of Facility Columbia Mortuary Services, P.A. Signature of Funeral Service Licen 9013 Annapolis Road, Lanham, MD 20706 /M00969 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Ph, sician/ disease or condition Atherosclerotic Cardiovascular Disease Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, any leading cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 f yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Failure to Thrive, Dementia, Parkinson's Disease Completed 1 Yes 2 X No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 XN 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6X Other (Specify) 2 K No မ 1 L Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1X Natural injury work? 1 ☐ Yes 2 ☐ No. 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Direcompleted filled in b Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis or examination and/or investigation, in his opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signatu and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Marrow June 21,2011 D53367 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 117 9801 Georgia Avenue Shyamsundar Rajan, M.D. Silver Spring, MD 20902 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kenneth Jordan	1	St - For State	ate of Maryla		artmen			Menta	al Hy		20		1966
Physician		Registrar 1. Decedent's Name (First, Midd	le,Last)		Timouto	, 0, 2			2	2. Date of Dea			3. Time of Death
Medical Examin											Day Yea 2011	ar	1709 hrs
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Funeral Director	-	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthda	″ ⊢	f Under 1 Year Months Days	If Under:	24Hrs. Min.	4	th(MM/DD/YYY) 3/1967	Foreig	ın
Director		216-06-9334	1X M 2 F	44	1	Yrs.				2/20	5/1907	Co	untry) MD.
any .	_	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or L	ocation							10d. Inside City Limits
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ne Maryland or 28a-f show fied at once	Director	MD N/ 10e. Street and Number	Α	I Da.	LCIMO		Of. Zip Code			1	0g. Citizen of WI	nat Cour	ntry?
the M a or 2	5	2793 The Ala	ameda				21218			- 1	USZ	Α	
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136 hin 72 hours after e. than "natural", edical Examiner	<u>a</u>	3 Widowed 4 Div 15. Decedent's Education (Spe	orced If Yes, Give Yea		1 146a Dan		s 2 X No Usual Occupation		ad af wa	ed done	Specify: 16b, Kind of Bu		lack
hour "natu	<u>ا ۋ</u>	Elementary/Secondary (0-12)			durir	ng most	of working life.	DO NOT us	se retire	ed)	TOD. KING OF BU	15111655/1	industry
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5-00 ed wit lygien other	Completed	17. Father's Name (First, Middle	, Last)	-			1	8.Mother's	Name (First, Middle, I	I Maiden Surname)	***
210 be fill rked	ge Re	David Jorda									xworth		
MD 21215-0036 d.2 should be filed within 7 in and Mental Hygiene. In 27 is marked other than 10 marked order than	-,	19a. Informant's Name/Relations			11 20						nber, City or Tow $MO~641.$, Zip Code)
	Н	Kevin D. Foxy 20a. Method of Disposition		204	Diana of Di		- /Nf	T		Date	20c. Location		Town State
Baltimore, semit. Pages 1 an Department of Hee important: If ite	-	1 Burial 2 Cremation 4 Donation 5 Other S	n 3 🔲 Removal fr	om State	crematory	or other	place)	+ 4			Balti		
tim t. Pag tment rtant:	- 1	4 Donation 5 Other S	p o o ii j i				e and Address						
Bal permi Depa Impo		White a full first service	K. m.				. Balt:	-	Ma e,	rch F, MD 21	/H TTO]	L E.	. North
Physician	+	23a. Part I. Enter the disease, or	complications that co	aused the deat								art	Approximate Interval
√ Medical	23a. Part I. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Complications of acute cardiorespiratory decompensation during of urpatient surgical procedure in the setting of hypertrophic attherosclerosis cardiovascular disease											Between Onset and Death	
Examiner		or condition resulting in death)	Due to (or as a	consequence	of):	ascm	ar urseas	SE					
	١	Sequentially list conditions,	b. Due to (or as a	202000110200	of):			-					
		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		consequence	or).								
st g	Examiner	events resulting in death) Last	Due to (or as a	consequence	of):								
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		IF FEMALE:	-23a.pt.	II.27.1	er me	.g91	7 7-25-	-11 sm	n		22d Data at	deliven	<u> </u>
Records, P.O. Box 68760 The law requires that the death certificate ficate has been signed by the attending phys. page 2 should be detached for use as the by		:: FEMALE: :3b. Was decedent pregnant in the past 12 months?		outcome of pre- irth	gnancy 2	Fetal	death 3	Ectopic p	oregnan	су	23d. Date of Month		Day Year
ox 6 ath cer attendi	<u> </u>	1 Yes 2 No 9 Uni	known -	ant at time of d	eath 5	Other	(Specify)						
the der	<u> </u>	Part II. Other significant condit	9 Ulkik		resulting in	the unde	erlying cause gi	ven in Part	1	23e Did to	bacco use contr	ibute to	the cause of death?
Records, P.O. Box The law requires that the death (cate has been signed by the atte	2	Morbid Obesit		dodin bac not	rocalting in	and and	only in ig sauce gr	70111111					oably 4 🗸 Unknown
Vital Records, P.C. bysician: The law requires that this certificate has been signed I director, page 2 should be determined.	Completed	NOIDIA ODESI	<u>- y</u>							24a. Was			topsy findings available
2 - COC	힑	-					-				rmed?	death?	completion of cause of
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/ital	ď	examiner? 1 ✓ Yes 2 No	Hospital: 1 🗸 I	npatient 2	ER/Outpa	itient 3					Residence 6	Other	
Division of Vital to a Attending Physician is after death. In Director After this certiled in by the funeral director.	<u>ا د</u>	27. Manner of Death	28a. Date	of Injury	28b. Time			at Work?			how injury occum		-
OD tending or: A or: A		Natural 5 Pend 2 Accident Inve	ding	, Day,Year)			1 Ye	es 2 N	10				
ViSi or Att frer de Direct in by	≝		stigation 28e. Plac	e of Injury - At I	nome, farm,	street, fa	actory, office bu	uilding, etc.	2	28f. Location (\$ or Town, \$		er or Ru	ral Route Number, City
Divis	Certification:	4 Homicide	rmined (Specify)							0. 10411, 0	nate)		
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To the within To the comple	ᄝᆚ	29b. Signature and title of certific	and manner s	tated.	androi illyes	oyallUl1,	29c. License		ou a(are une, uate	29d. Date sign		
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	L	20 Name and address of second	who completed ac-	e of dooth /lt	n 23al						10,2		
XJ		 Name and address of person Ana Rubio MD. Ass 	i who completed caus sistant Medical E			3altimo	ore Street, E	Baltimore	e, MD	21223			
) V Sta	te i	31. Date filed (Month 1987, Year)	32 Ré	istrar's Signa			w						
Registr		11 IN 9 9	L 2011 Z			44	W. J						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 June 15, Thomas William James 5:20 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium 5. Social Security Number **Funeral** . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 D F Hours OCT. 24 Ye Year) 1939 West Virginia 219-26-8288 Director 71 Usual Residence of Decedent 28a-f show within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 🗆 Yes 2 🎦 No Maryland Harford Fallston 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2110 Givenswood Drive 21047 **USA** 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force 1 Never Married 2 Married Black White etc. "natural", or 2 1 ☐ Yes 2X No If Yes, Give 1 Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than alth and Mental Hygiene. 27 is marked other than r traumatic event, the Mi Elementary/Seconday (0-12) College (1-4 or 5+) 11 Truck Mechanic Automobile Dealer Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Everett Lee James Thelma Belle Straight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health s Virginia James / Wife 2110 Givenswood Drive, Fallston, Maryland 21047 other item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. ☐ Burial 2 【**Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 6-17-2011 Towson, Maryland . Signature of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Physician/ LUNG CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): as the burial-transit Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician by Physician/Medical or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: nse yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 24a. Was an Director: After this certificate has autopsy performed? Yes 2**X** No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 💢 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work? Accident
Suicide
Homicide 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Mithin 24 hours after To the Funeral Direction 28f. Location (Street and Number or Rural Route Number, City or Town, State) TX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Under the cause of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Under the cause of the basis of my knowledge, death occurred at the time date, and place, and due to the cause of the cau 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIO MAHMOOD. MD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 25 per me,g916,06/20/2011dhb
Registrar

State of Maryland / Department of Health and Mental Hygiene
Registrar Reg. No. 3. Time of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Johnson Medical Town, or Location of Death 4c. County of Death **Examiner** timo 8. Date of Birth (Month, Day, Y Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 F Months Hours 30-27/2 MD Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State Director 1 Yes 2 ☐ No ltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Koaa lun bridge Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc 1 ☐ Yes 2 X No If Yes, Give ģ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify: 3 Widowed 4 ☐ Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cleaning leaning Be Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) မ ohnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type: Print) Ho., phnson Daughte 10 injury or other a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1101 E. North Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. terval Between shock, or heart failure. List only one cause on each line. and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) to (or as a consequence of): **Examiner** OC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury MEDICAL EXAMINER Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transif that initiated events resulting in death) Last ION APP Due to (or as a consequence of): CERTIFICA Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) been signed by the a should be detached 9 | Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 Probably 4 Unknown 1 🗌 Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe 1 🗌 Yes 2 🔲 No this certificate director, Was case i 26. Place of Death (Check only one) Hospital: Other: ၉ 1 X Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral Manner of Death 28c. Injury at work? 1 ☐ Yes Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 2 🗌 No Investigation Accident 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) Registrar's Signa State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11:13 AM Arthur Paul James Sr. Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 □ F Months Dec. 19, 1928 W. Virginia Director 235-38-6257 82 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Bel Air 1 🗆 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 140 F Royal Oak Drive 21015 USA or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 XMarried Black, White, etc. Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify. 'natural", 3 Divorced 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Chemical Elementary/Seconday (0-12) College (1-4 or 5+) Plant Technician 12 Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Warder Andrew James Nora Gay Marks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 140 F Royal Oak Drive, Bel Air, Maryland 21015 permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra <u>Bettv J. James / Spouse</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Lake View Memorial Pk 6-20-11 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) f Funeral 9 rvice Lic 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause or sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Ph_sician/ Onset and Death in disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events sician and burial-trans resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Pregnant at time of death Month Day 2 No the 9 Unknown Unknown <u>P</u>. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 ☐ Yes 2 🛮 Yoo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 No 1 Yes 2 No Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 000 Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ō 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury ☐ Accident 5 Pendina work' Division Investigation 1 Yes 2 No Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined within 24 hours a To the Funeral I the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b, Signature and title of certifier 29c. License number JUNE 16,20/1 address of person ed cause of death (Item 23a) (Type, Print) hesapeake Drive HOMF

DHMH 17 Rev 7/2009

State Registrar 32. Registr

Land

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e&f Per FH G916 6/27/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Ruth Kirk Year 6:28 PM Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N. Carey Street Balt: more 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 217-26-4488 Months Days Director MARGLE not Usual Residence of Decedent "natural", or items 23a or 28a-f show within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Md Baltimore 1 Yes 2 No 10e. Street and Number 1043 10f. Zip Code 21223 10g. Citizen of What Country? Lexington ST Funeral 1. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. med Forces?
☐ Yes 2 🗹 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 Yes, Give 1 Yes 2 No Specify: Black Specify. Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me ones. Elementary/Seconday (0-12) College (1-4 or 5+) +0+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidep Surname) မ Simmons Albert talker 19a. Informant's Name/Relationship (Type, Print) Hoshard 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) Author Carey Street 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial, 2 ☐ Cremation 3 ☐ Removal from State -24-11 4 Donation 5 Other (Specify) ARbotus MemPK 21. Sign ture / Fun rd Se vice 22. Name and Address of Facility was 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ End- Stage (ardiomyopath) Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 INO Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury work Accident Investigation М 1 ☐ Yes 2 ☐ No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) nskajapalneM.D 6/18/11 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 5-703 MD 21209. N S Rajapakse, M.D 2835 Smith 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:12 P Raymond John Knee June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Health Systems Bel Air Harford . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 219 38 9040 Director West Virginia Feb. 7, 1942 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location with the Maryland notified at Funeral Director 28a-f Maryland Harford Edgewood 1 🗌 Yes 2X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? must be r 1832 Steven Drive 21040 Harford r than "natural", or items the Medical Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Technician Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ည Pearl Saucer Herbert John Knee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Brenda Knee 1832 Steven Drive Edgewood, Maryland 21040 (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gardens 6/21/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 21. Signa (re/o) Funeral Service Licenses Maryland 21221 1407 Old Eastern Avenue Essex 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ventricular disease or condition Medical resulting in death) Examiner yocardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 FR/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manne of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation Accident Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) whithe 00066035 6,17,2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) poer chesapeake Drive Bei Ar, MD 21014 31. Date filed (Month, Day, Year) 32. Registra 's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 - For**State
Registrar Reg. No./ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2:15 PM Krone berger Physician/ Theresa 7011 June Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Carroll Eldersburg 2112 Cottage Hill Ct g. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 X Days Hours March Das Year 1927 MaryTand 84 Yrs. 214-22-1681 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State within 72 hours after death with the Maryland Director 1 Yes 2 XNo ral", or items 23a or 28a-f s Examiner must be notified Baltimore Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 Funeral 3 Ginford Place unit 203 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?
1 ☐ Yes 2 ☐ No ģ 1 Never Married 2 Married 1 Yes 2 No Specify Baltimore, Maryland 21215-0036 Specify: White If Yes. Give Completed 3 X Widowed 4 Divorced Year or Dates Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) l Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Banking Mortage Officer the 2 should be filed with and Mental Hygie 7 is marked other 18. Mother's Name (First, Middle, Maiden Surname) other traumatic event, Be 17. Father's Name (First, Middle, Last) Margaret Anna Horan John P. Mc Gowan permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4035 Salem Bottom Rd., Westminster, Maryland 21157 Theresa M. Menefee/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State New Cathedral CemeteryJune 20,2011Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. uneral Service Licensee Si a ature 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death End-Stage Renal Disease Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23d. Date of delivery for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Year in the past 12 months?

1 Yes 2 No Month Dav 4 Pregnant 9 Unknown Pregnant at time of death signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown cate has been sig Completed 24b Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy performed Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes မ this 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined the Hospital or Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier os Rujapahrem.D 00057465 6/16/11

State Registrar

N. S Rajapakse, M.D 31. Date filed (Month, Day 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 SMITH

AV 5-203

Baltimon, MD. 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day Year Ruth M. Krebs 25 2011 TUNE Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL TOWSON BALTIMORE Date of D. (Month, Day,) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 **Director** 93 Ĩ'918 214-03-1918 Jan. Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Timonium 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA 8 Bally Cruy Ct. #201 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give 1 ☐ Yes 2 No Specify Specify: white Completed 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant General Motors Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alberta G. Schmidt George J. Hoeflich 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7209 Meadow Wood Way, Clarksville, MD 21029 Mrs. Barbara M. Schmidt/lst cousin or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot ■ Burial 2 □ Cremation 3 □ Removal from State 6/23/11 Parkville, MD Donation 5 Other (Specify) Parkwood Cemetery 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
O W. Padonia Rd., Timonium, MD 21093 21. Signature of Fune Michael J. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between On et and Death Immediate Cause (Final disease or condition Physician/ Bleedi Medical resulting in death) Due to (or as a consequence of) Examiner nemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and tran Due to (or as a consequence of) attending physician Physician/Medical Box 68760 as the l IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Or in the past 12 months?
1 Yes 2 No Month Day Year the detached 9 Unknown P.O. | by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 24 hours after death. Funeral Director: After this certificate 1 Yes 2 No Yes 2 the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 00 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [within 2 To the I only one 30. Name and address of person 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gabriella Daley 05:51 2011 06 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maryland University of Baltimore Social Security Number 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Country) MD 1 🗆 M 2 🕱 F Hours May 26, Year 966 220-60-6737 45 Director Usual Residence of Decedent 28a-f show ms 23a or 28a-f sho must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8409 Oakton Lane, Apt. 3F 21043 United States ed other than "natural", or items event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 KNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give 3 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Director Publishing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John P. Dalev Patricia A. Oliver injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 i Gregory P. Klatt - husband 8409 Oakton Lane, Apt. 3F, Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 06-20-2011 Glen Burnie, Maryland f Funera Service Lice 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Later the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Metastatic Non-Small Cell Lung Carcinoma unknown Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence on Exami sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 X Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₫ cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an performed?

1 Yes 2 No death? After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 💢 No Hospital Other: ျှ 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29c. License number P24327 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Street Baltmore 22 South rochmal

DHMH 17 Rev 7/2009

State

Registrar

JUN 2 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 16. 2:45 June A M Mary V. Koenig Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Manor Care Potomac 8, Date of Birth (Month, Day, Ye March 28 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Numbe 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🕅 F 191-20-5140 86 1925 Pennsylvania Director Usual Residence of Decedent Show 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 💢 No Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20814 United States 4403 West Virginia Avenue be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married ☐ Yes 2 K No þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 X Widowed 4 □ Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Il Hygiene. College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental P permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is many injury or other ၉ Valent Didik George Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4815 Hornbeam Drive, Rockville, Maryland 20853 Francois Koenig / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June Date 21. cemetery, crematory or other place)

Gate of Heaven Cemetery 1 Burial 2 Cremation 3 Removal from State Silver Spring, Maryland 2011 4 Donation 5 Other (Specify) Signature of Funeral 9 Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Ingeletta Barrers M01305 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final - Physician/ Recurrent Retractory Endometrial Sarcoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Requiringly list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death been signed by the should be detached 1 ☐ Yes ∠ ⊆ g ☐ Unknown g | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of or Attending Physician: The law page 2 s this certificate has autopsy 1 ☐ Yes 2 ☐ No Yes 2X No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 🗓 No 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 X Natural 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred s after death. (Month, Day, Year) injury work?
1 Yes 2 No 5 Pending To the Hospital or Attendii within 24 hours after death.

To the Funeral Director. At completed filled in by the fu 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

State

Medical

29a. Certifier

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 9801 Georgia Avenue, Ste. 117, Silver Spring, Maryland 20902 Sunitha Bhogavilli, Date filed (Month, Day

1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

Defining in National Continuous and for investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0054566

29d. Date signed (Month, Day, Year)

June 16, 2011

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔈 🗍 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day JUNE 201^{Year} Physician/ 1:00 A M KATZ **THERESA** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON GILCHRIST HOSPICE CARE If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday Social Security Number **Funeral** Min. 1 M 2 F Months Hours 0372071931 NY **Director** 217-26-9941 80 Usual Residence of Decedent and Mertal Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he mattered at 10c. City, Town or Location 10a. State 10b. County by Funeral Director 1 💢 Yes 2 🗌 No BALTIMORE MD N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 6711 PARK HEIGHTS AVENUE, #114 21215 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) MEDICAL ASSISTANT MEDICAL 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ COLERO PLOTKIN THERESA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6711 PARK HEIGHTS AVENUE, #114, BALTIMORE, MD 21215 SIDNEY KATZ/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 M Burial 2 Cremation 3 Removal from State 06/19/2011 TAYLORSVILLE, MD BETH SHALOM CONGR. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Matt Le 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and strans Due to (or as a consequence of) resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) Day in the past 12 Month Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 Yes 2 No Yes After this certificate 26. Place of Death (Check only one) Be 25 Was case referred to medical Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 27. Manner of Death 28c. Injury at Natural 5 Pending 1 Yes 2 No death. Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined completed filled in by Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year, 29b. Signature of death (Item 23a) (Type, Print) houleest. Suite 4105, State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vivian Ferrell Laue 6:00 P M June 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Kline Hospice House Airy If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 1 □ M 2 🕱 F North Carolina **Director** 244-36-9073 Aug 84 Usual Residence of Decedent 28a-f show 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No Frederick Maryland Frederick 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 21702 1012 Bexhill Drive Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 X Married Completed by 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than. Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Federal Government 4 Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alonia Cockrell Henry Berry Ferrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 1012 Bexhill Dr. Frederick, MD 21702 Henry J. Laue / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 6/21/2011 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service License Coing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LEUKEMIA ACUTE disease or condition PROMYELO CYTT & Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 | Yes 2 No Pregnant at time of death 9 I Unknown detach ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, SPINAL STENOSIS, HYPECTENSION, CEREBRAL 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available ANEURYSM, HYPOTHYROID certificate has the lirector, page 2 s autopsy prior to completion of cause of death? performed 1 Yes 2 No Yes 2 V No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred I Director: After t d in by the funera 1X Natural 5 Pending worł 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 V

State Registrar Date filed (Month, Day, Year)

melson

DONELSON MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Server S. Signature

65C

THOMAS JOHNSON

DZ1936

DR, FREJERICK MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 13 2011 2:20 PM Deane Clark Laycock June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Parkville Baltimore Oak Crest Renaissance Gardens If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕅 F Months Hours Yrs. Maryland 90 Director 213-14-0804 Usual Residence of Deceden 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 1 ☐ Yes 2 🎇 No Maryland | Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Boulevard #2429 21234 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. þ 1 Never Married 2 Married | \(\(\lambda \) (U \) (Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Trust Officer Trust Company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Sadie Robinson Robert Otto Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1210 East Joppa Road Towson, Maryland 21286 Craig Spencer, Personal Rep 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 🗌 Burial 2💢 Cremation 3 🗌 Removal from State 06/20/11 Metro Crematory Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Thomas Gregor 22. Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 Lomo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one caus Interval Between Immediate Cause (Final erebrovascular hysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death page 2 should be detached signed by the P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertensive Cardiovascular 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Disease (Malignan 24a Was an autopsy performed has Director: After this certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 일 Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar mpleted cause of death (Item 23a) (Type, Print)

MSN

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

8800 Walther Blud, ParKville MD 21234

29d. Date signed (Month, Day, Year)

11-03894 Michael Kenneth	Мо		pe or Print i tate of Maryl							egibl	e.	A	1968(
		1- For State Registrar		Cer	tificate o	f Death				Reg. No			
Physicia Medical Exami	an/	1. Decedent's Name (First, Midd Michael Kenr		on III					2. Date of De Month May 24,	Day 2011	Year		3. Time of Death 1945 hrs
		4a. Facility Name (if not institution 1913 Seven Oaks Te		iumber)		4b. City, Towr Crofton	n, or Loc	cation of Death			c. County o Anne Art		
Funeral		5. Social Security Number unk		7. Age (In yrs. Ia	ast birthday)	If Under 1	Year I	If Under 24Hrs.	8. Date of E				place (State or
Director		Usual Residence of Decedent	1 M 2 F		55 Yrs	Months	Days	Hours Min.	June			Foreign Coun	ulik
w any		10a. State 10b. County		10c. City,	Town or Local								Od. Inside City Limits
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the Maryland t or 28a-f show	Director	10e. Street end Number 1913 Seven C	aks Terra	ace		10f. Zip Cod		21114		10g. Cit	izen of Wh USA		y r
death with t rritems 23a nust be not	Funeral	11. Mailtai Status	11 12. Was De Armed I	ecedent Ever in U. Forces? U1				nic Origin? (Spe lexican, Puerto F		10-	14. Race White	, etc.	an Indian, Black,
after	ğ		vorced If Yes, Give Ye or Dates:		1	Yes 2 X					Specify:	whi	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho- iojury or other traumante event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12) unk		ede completed) (1-4 or 5+)	16a. Deceder during m	nt's Usual Occ nost of working	upation life. Do	(Give kind of wo O NOT use retire	ork done un ed)	ık 166.	Kind of Bus	siness/Ind	dustry unk
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ould b		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailin	g Address (S	Street ar	nd Number or Ru	aral Route N	umber, C	ity or Towr	n, State, Z	Zip Code)
MD nd 2 sho alth and m 27 is		O.C.M.E.		l ani				re Stre					21201
Baltimore, permit. Pages 1 ar Department of Hee importact: If ite		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, S crematory or other place)										own, State	
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Ba Derm Derm Imp	ı	21. Signature of Funeral Service	ST Wate	Director				my Boar MD 212		W. 1	Balti	nore	Street
Physician		23a. Part I. Enter the disease, or failure. List only one cause		caused the death.	Do not enter t	he mode of dy	ing, suc	ch as cardiac or	respiratory a	rrest, sh	ock, or hea	ert	Approximate Interval Between Onset and
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	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	6 1232	a consequence of	f):								
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tox 68760, leath certificate be ex e attending physician for use as the burial		IF FEMALE: 23b. Was decedent pregnant in to past 12 months?	he 1 Live	, outcome of pregr birth	2 🗌 Fe	etal death	3	Ectopic pregnan	су	23	Id. Date of Month	Da	y Year
OX (eath ce attend for use	Sici	1 Yes 2 No 9 Un		nant at time of de nown	ath 5 O	ther (Specify)				1500			
O. B at the d by the		Part II. Other significant condit		to death but not re	esulting in the	underlying cau	se give	n in Part I.	23e. Did	tobacco	use contril	oute to the	e cause of death?
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of Vital Recing Physiciae: The After this certificate uneral director, page	입	1 Yes 2 No 27. Manner of Death		Inpatient 2	ER/Outpatient 28b. Time of				Home 5		ence 6		Scene
Division of Vital Records, P.O. Box 68760, ral or Attending Physiciao: The law requires that the death certificate be re after death. al Director: After this certificate has been signed by the attending physic led in by the finneral director, page 2 should be detached for use as the burn	ation	1 Natural 5 Pen	ding estigation (Mon	th, Day,Year)		1[Yes	2 No					
Divis pital or A ours after eral Dire	Certification:	4 Homicide dete	ald not be armined (Specify	ce of Injury - At ho	ome, farm, stre	et, factory, offi	ce build	ding, etc.	28f. Location or Town,		and Numbe	er or Rura	Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Medical (Concent any	Physician: To the beaminer: On the basis and manner	of examination a	_								
F 3 F 3	Me	29b. Signature and title of certific		41	1		ense n			122	Date signe y 25, 20		h, Day,Year)
	ł	30. Name and address of persor											
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St	ate	31. Date filed (Month/TDby, Tear)	32. 5	gatcar's Signatu	-	-							

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jume 18, 5:26P 2011 Stella Marko Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore Villa Maria Health Care If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 - M 2 X F Months 1472371923 Pennsylvania 88 189-16-7382 Director Usual Residence of Decedent or 28a-f shov 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location Director 1 Yes 2XXNo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 USA 6401 North Charles Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14, Race - American Indian 11, Marital Status Yes, specify Cuban, Mexican, Puerto Rican. etc. rmed Forces? Black, White, etc. 1 X Never Married 2 Married by Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Me College (1-4 or 5+) Elementary/Seconday (0-12) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anna Filachek Andrew Marko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6401 North Charles Street Baltimore, Maryland 21212 Sister Bernice Feilinger SSND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State Villa Maria Cemetery D6/23/2011 |Glen Arm, Maryland Donation 5 ☐ Other (Specify) 22. Name and Address of Fittitchell-Wiedefeld Funeral Home Inc anature of Funeral 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, complication Approximate Interval Between Onset and Death shock, or heart failure. List only one cau Immediate Cause (Final Physician SIDAS disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 3 Probably 4 Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has I autopsy death?
1 Yes 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No funeral director, Be 26. Place of De (Check only one) Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) er of Death 27. Mag 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director. At completed filled in by the ft. death. 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number DOGR 8173 29d. Date signed (Month. Day, Year) AHonduna love go, 201 30. Name and address of person who com se of death (Item 23a) (Type, Print) N. Charles St, Suite 425

Registrar DHMH 17 Rev 7/2009

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31. Date filed (Month, Day, Year)

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) June Physician/ 18 Colburn Michaels Elizabeth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Cockeysville Broadmead If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 💢 F 02%96*/*1908 Maryland 103 Director 216-46-7299 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 No Baltimore Cockeysville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21030 USA 13801 York Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 \square Never Married 2 \square Married Completed by 1 ☐ Yes 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Proctor Brady George Selwyn Colburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son George S Michaels 11815 Sherbourne Drive Timonium Maryland 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

GreenMount Crematory 06/21/2011 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) nature of Funer 22. Name and Address of FMItchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the diseasi, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ISCHEMIA OF RIGHT LE Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 T No Month Year 1 Yes 2 4 within 24 hours after death.

To the Funeral Director: After this certificate has been signed by i completed filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** 2 No Other: မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🛂 Natural work' 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical V Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Contifying Nurse Practioner. To the best of my knowledge, death occurred at the fine-date and claim, and due to the naiso(s) and mariner as status within 2 To the I 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) ARROLL 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

		For State Registrar 1. Decedent's Name	e (First, Middle, L		/iarylan		partment of I partificate of L		2. Date of De	Reg. No. 2	Contraction	1 9 6 9 3 3. Time of Death
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Examin	er	Gilchris	t Cente				Towson	r Location of D	reatri	Ba	nty of Death altimo	re
Funeral Director		5. Social Security Number 212-26-5687 Usual Residence of Decedent			ast birthday) Yrs.	If Under 1 Year Months Days				9. Birthplace (State or Foreign Couptry) Maryland		
/aryland Ba-f show tified at		10a. State MD	10b. County Baltin	nore		y, Town or L					1	0d. Inside City Limits 1 Yes 2 No
with the I s 23a or 2 nust be no	Funeral Director	10e. Street and Number 4 Lona Court				10f. Zip Code 21236			10g. Citizen o	of What Cour USA	ntry?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 XXWidowed 4 □ Divorced 12. Was Decedent Eve Armed Forces? 12. Was Decedent Eve Armed Forces? 14. Was Decedent Eve Armed Forces? 15. Was Decedent Eve Armed Forces?		?	If Yes, specify Cuban, Mexican, Puerto			? (Specify Yes or No- uerto Rican, etc.)	ify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White			
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permit Depar Impor any in		21. Signature of Fu	neral Service Lice	ensee			22. Name and Addre 9705 Bela					e, Inc. 236
Physician/ Medical Examiner pnulal-transit	Examiner		rt failure. List only (Final on anditions, nmediate rlying ilinjury s	a. Due to (or a	s a consequence of a co	OAS uence of):	TR UCTIV	_			<u>se</u>	Approximate Interval Between Onset and Death
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Physician: The law requ r this certificate has beer aral director, page 2 shou				etery D ABETES A	1066	170			1 🗆 Yes	opsy ormed		psy findings available impletion of cause of
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To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completed filled in by the funer	al Certificate:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)						mber or Rura	l Route Number,			
n 24 hou n 24 hou e Funer oleted fill	Medical	(Check 2	🖳 Medical Exa	hysician: To the best iminer: On the basis o urse Practioner: To the	f examinatio	n and/or inve	estigation, in my opini	ion, death occu	rred at the time, date	and place, and	due to the ca	use(s) and manner stated
To the Complex		29b. Signature and title of certifier					29c. License number			29d. Date signed (Month, Day, Year)		
rly		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALCHAEL ACKNOWN 6 FCI NOWN STEAMS STEAM BRITMORE MOZIZEL 31. Date files (Negritar) Page 1994										MOZIZA
Stat Registra		31. Date filed Mont	2 1 2011	Deser SZ. Hegis		Anna.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 9581 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Meister 18,2011 June 1:25A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Balto. Nottingham 4331 E. Joppa Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Months March 15,1946 1 🛛 M 2 🗆 F County Maryland **Director** 65 212-44-0548 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Nottingham Balto. Md. 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 USA 4331 E. Joppa road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc Completed by 1 Never Married 2 X Married 2 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates.1964-1967 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Port of Baltimore Cruise Director Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Janet Preston John D. Meister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4331 E. Joppa Road Nottingham, Md. 21236 Spouse Barbara Meister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 LyBurial 2 Cremation 3 Removal from State 6-21-2011 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Md. Dulaney Valley 22. Name and Address of Facility Schimunek FuneralHome 21. Signatore of Funeral Service Licensee Nottingham, Md. 21236 9705 Belair rOad 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Ph_sician/ John most disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (огаз в попяноння Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and -tran Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months? Pregnant at time of death ed by the a detached f 2 No g Unknown certificate has been signed rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 X No မ 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Funeral Director: After this eted filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury death. 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 2 nd address of person who completed cause of death (Item 23a) (Type, Print) 21236 4136 13

DHMH 17 Rev 7/2009

State

Registrar

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G917, 7/26/2011, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNET 1 Pay 2011 7:20 P M CHARLOTTE MARGARET MULLEN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD 22**0=03**45251 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last hirthday) **Funeral** FEB. 22, 1920 1 □ M 2 🔀 F Hours Min. 91 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD HARFORD ABINGDON 1 Yes 2 X No 9 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 309 TALL PINES CT. APT C 21009 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. should be filed within 72 hours after of and Mental Hygiene. is marked other than "natural", or i þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 🙀 No Specify 3 Xwidowed 4 ☐ Divorced Specify: WHITE Maryland 21215-003 Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev CHARLES B. CORCORAN MARGARET A DUERE 19a. Informant's Name/Relationship (Type, Print)
CAROL GRAHAM-DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $1205~{
m GLASTONBURG~WAY}~{
m BEL~AIR,~MD}~21014$ Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date DULANEY VALLEY 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 6/22/11 BALTIMORE, MD Signature of Funeral Service Licenses 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BEL AIR MD 21014 610 W. MACPHAIL RD BEL AIR, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ongestive disease or condition Medical resulting in death) Due (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to (or se a noneequence of) It any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last burial physician at the burial Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 □ No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part !. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? certificate 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 2 ER/Outpatient 3 DOA 1 Inpatient Director: After thi Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours are
To the Funeral Dir Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner To the best of my knowledge, deeth oncomed at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) wie (une MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (01 32. Regis ra 's Stanature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Physician/ Santo 17:01 AM Miceli Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1264 Rock Hill Road Pasadena Anne Arundel If Under 8. Date of Birth 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, July 9. 1<u>939</u> 1 X M 2 - F Months Hours Min Country) 216-36-3893 **Director** Marvland Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** be notified 1 Yes 2 No Maryland Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Number iral", or items 23a Examiner must b 1264 Rock Hill Road 21122 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ "natural", or Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) r than ". Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Baltimore City Firefighter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Benjamin Miceli Florence Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. <u>Gloria J. Miceli (Wi</u>fe) 1264 Rock Hill Road Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 S Cremation 3 Removal from State 06/21/2011 4 Donation 5 Other (Specify) Atlantic Cremation Glen Burnie, Maryland 21. Signature of Fymeral Service Licenses McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lung Ph_sician/ cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has be lirector, page 2 s autopsy performed? death? 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral s after deatn.

I Director: After the din by the funers Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical 🔟 🕳 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier MM D 29d. Date signed (Month, Day, Year) 29c. License number D0057 465 6/18/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N-S. Rajapakse, M.D Baltimore MD 21209. 2835 Smith AV 7 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death Physician/ Lan Zheng Mai 19^{Day} 10:34 AM Hsiao JUNE 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) China Year) 957 Hours Min Feb. / 1 🗆 M 2 🕱 ! 219-49-6676 54 **Director** Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Tes 2 No MD. Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 China 8330 Loch Raven Blvd. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 K Married þ 2 X No 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian Specify: Completed 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 16a, Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ unknown Chang Qi Zheng 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Hing Mai/ Daughter 8330 Loch Raven Blvd Baltimore, MD. 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6-22-11 Woodlawn, MD. 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cem. 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 21. Signature of Juneral Solvice License 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition 1 Onsetand Death Ph_sician/ PNEUMONIA Medical resulting in death) Due to (or as a consequence of): Examiner MYELODYSPLASTIC SYNDROME 3 YEARS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death ed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed | rector, page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗓 No Other: ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 🗡 Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident within 24 hours after death

To the Funeral Director: / Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number D 36663 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

STUART R.

31. Date filed (Month, Day, Year)

WILLES,

M.D.,

7601 OSLER DRIVE, TOWSON,

MARYLAND 21204

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1 - State Amend Items 23a PtI, 23e per me, g916, 06/10/2011dhb

Registrar

Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MCMICHAEL Physician/ Month 5 Year 201 OROTH 1048 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Greenspring Ave Apt T4 Baltimore If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 24 Hrs **Funeral** 1 M 2 KF Days Months Hours Min Director 220-64-5737 28a-f show 10a. State aţ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Baltimore NA 1 XYes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? T4U.S.A. 21209 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 X Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify "natural", Specify: BLACK Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) SECIZ 2 should be filed with h and Mental Hygien 7 is marked other tt grade 2vrs+ Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) George McMichael Bernice Emerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trau Dominic Little-Son 3002 Seamon Ave, Baltimore, Md 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State W☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date ☐ Donation 5 ☐ Other (Specify) /2011 Zion Baltimore, Md Signatur of Fineral Service License Masch F/H We 4300 Wabash ëšt Ave, 21215 Baltimore, Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line Probable Myocardial Infarction Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Hypertension Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir and I-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 physician CERTIFICAT Physician/Medical Records, P.O. Box 68760 attending phys IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page, performe 2 🗆 No Yes 2 No **Division of Vital** funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗆 No 1 Yes Other: ျ 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a

To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type 1ZABE 1501 MT ROYAL 32. Registrar's Signature State Registrar

11-04546 James Merritt Please Type or Print in Black Indelible Ink. Ensure All Conies Are Legible

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State of Maryland / Department of Health and Mental Hygiene	2011	195

lames Merritt		Since State Registrar	ate of Maryla	ind / Depa		Health and			2 0 eg. No.	11 19589
Physici		Decedent's Name (First, Midd					·	2. Date of Dea Month		3. Time of Deeth
Medical Exam	iner	James 4a. Facility Name (if not institution		rritt	1/	b. City, Town, or L	costion of D	June 17, 2	2011 4c. County o	1317 hrs
Ţ		Bayview Hospital	ori, give street and nor	iliber)		Baltimore	ocalion of Di	adui	4c. County o	i Death
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24		rth(MM/DD/YYYY)	9. Birthplace (State or
Director		579–62–1082	1XM 2 F	63	3 Yrs.	Months Days	Hours	May 11	, 1948	Foreign Washington
any .		Usual Residence of Decedent 10a. State 10b. County		I10c. City	, Town or Location	nn .				10d. Inside City Limits
	L	Maryland Balt	imore		Dunda					1 Yes 2 No
daryla 28a-f	Director	10e. Street end Number		1		10f. Zip Code		1	0g. Citizen of Wha	at Country?
eath with the Maryland items 23a or 28a-f sho ust be notified at once.		7429 Holabird A	Avenue				1222		USA	
ath wit tems 2	uneral	11. Marital Status 1 Never Married 2 X M			J.S. 13. Was	Decedent of Hispa s, specify Cuban, I	anic Origin? Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Race - White,	- American Indian, Black, etc.
fter de '', or i	ш		1 Yes rorced If Yes, Give Year	2 X No	1	Yes 2 X No	specify:		Specify: W	White
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f ahe out, the Medical Examiner must be notified at once	bd by	15. Decedent's Education (Spe	Lor Dates: cify only highest grad	e completed)	16a. Decedent	s Usual Occupation	n (Give kind	of work done	16b. Kind of Bus	
36 in 72 h	plete	Elementary/Secondary (0-12) 12 years	College (1-					retired)		
5-0036 ed within 7 tygiene. other than	Completed	17. Father's Name (First, Middle	4 year	<u>S</u>	Kit	chen Desi	_	ame (First, Middle, I	Home De	epot
21215-00; uld be filed withi Mental Hygiene, marked other th	BB	George W. Merr						A. Palme	,	
MD 21215-0036 11 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medica	٦	19a. Informant's Name/Relations Deborah Merrit		£-				or Rural Route Num		
_ = 3 5 5		20a. Method of Disposition	e wi			HOLADITO		e, Dundal		and 21222 City or Town, State
Baltimore, oemit. Pages 1 and Department of Heal Important: If item night or other tra	1	1 Burial 2 Cremation		m State	crematory or oth	cemetery	J.	une 22, 2011		Maryland
Baltimo permit. Page Department of Important:		4 Donation 5 Other Si 21 Signatu uneral Service		1/1		-	- 1		3	
	Ц	Minory	Connel	y	71	10 Soller	s Poi	Home Of nt Road,	Dundalk, Dundalk,	Md. 21222
Physician // Medical		23a. Part I. Enter the vises se, or failure. List only one cause	on each line.	0	i. Do not enter th	e mode of dying, su	ich as cardia	c or respiratory arre	est, shock, or hear	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Acut Due to (or as e		ural Hen	natoma				Death
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Box 68760 e death certificate be the attending physical d for use as the bu	읗	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, o	utcome of preg)		23d. Date of d	
ox 687 eath certific attending	iciar	past 12 months?	4 Pregna	nt at time of de	agth -	aldeath 3 er <i>(Specify)</i>	Ectopic pre	gnancy	Month	Day Year
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on of Vital Records, P.O. Box 6876(ending Physician: The law requires that the death certificate ath. or: After this certificate has been signed by the attending physhe funeral director, page 2 should be detached for use as the b		Hypertensio		death but not r	esulting in the ur	derlying cause give	en in Part I.			ute to the cause of death? Probably 4 V Unknown
cords,	Completed by						<u> </u>	24a. Was a	an 24b. W	ere autopsy findings available
ecol he law ite has	gm							_ autop: perfor 1 ✓ Yes	med? de	ior to completion of cause of eath?
Vital Rec ysiciau: The l his certificate l	Be	25. Was case referred to medica		-			Death (Che		2 NO 1	Yes 2 No
F Vit		examiner? 1 ✓ Yes 2 No		patient 2	ER/Outpatient			sing Home 5	Residence 6	Other:
Division of Vital Records, talor Attending Physician: The law requir is after death. **I Director: After this certificate has been sted in by the funeral director, page 2 should the fine of the funeral director, page 2 should the funeral director.	ë	27. Manner of Death 1 Natural 5 Pend		Day,Year)	28b. Time of Inj		at Work?	_	now injury occurred	d
r Atter dea irector	ficat	2 Accident Inves	tigation	-17-11 of Injury - At he	unknown ome, farm, street	factory, office buil		unknowi 28f. Location (S		or Rural Route Number, City
Div pital o	Certification:	4 Homicide deter		rehabi	litation	center			tate) 7429 1	Holabird Ave.
Division To the Hoopital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	_ !	29a. Certifier (Check only one) 2 Medical Exam	nysician: To the best miner:On the basis of	of my knowled	ge, death occurre	ed at the time, date	and place, a	nd due to the cause	e(s) and manner a	es stated.
To t Com	Medica	29b. Signature and fitle of certifie	and manner sta	ated.		29c. License r		unid, date &		(Month, Day, Year)
		(), /	Lo mo)		O.C.M.	E.		June 18, 20	
	İ	30. Name and a dress of person			,				V	
		Laron Locke MD. A 31. Date filed (Month, Day, Year)	ssistant Medical	Examiner		timore Street,	Baltimore	, MD 21223		
Regist		IIIN 2 1 2011	Beren SZ. Reg	A Sa	Kal					
		J. T. T. T.	782.	. 77						

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State of Maryland / Department of Health and Mental Hygiene Joseph Starr Miller Certificate of Death 1- For State 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day June 12, 2011 0037 hrs Joseph **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Johns Hopkins Hospital 9. Birthplace (State or 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number **Funeral** Director 32 Yrs Country) Marylan 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No Maryland Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygene.

asti. If item 77 is marked other than "natural", or items 23a or 28a-f sho no other trannatic event, the Medical Examiner must be notified at once, 10g. Citizen of What Country 10e. Street and Number Kase 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married Yes 1 Yes 2 No specify: f Yes, Give Year or Dates: 4 Divorced 2 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Laborer 18. Mother's Name (First, Middle, Maiden Surname 17 Father's Name (First, Middle, Last) Gwendolyn Fennes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lakeshia Miller 20a. Method of Disposition City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Marylan Lion Gemeler Donation 5 Other Specify: 5 21. Signature of Funeral Service Licensee timore Approximate Interval 23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart Physician /Medical Between Onset and failure. List only one cause on each line. Immediate Cause (Final disease a Alcohol and oxycodone Intoxication Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g916 6-30-11 sm attending physician a X UNPENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death Year Live birth 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) ned by the atte 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 2 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been subneral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Other Nursing Home 5 Residence 6 Other 1 Yes 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending death. Director: fd 11:50 pm Unknown Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide or Town, State) 452 N. Clinton St. Baltimore, Md. determined Found in his vehicle To the Funeral Homicide 29a. Certifier 1 (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number COME June 12, 2011 O.C.M.E. of death (Item 23a) 30. Name and address of person who completed cau Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Theodore M. King, Jr., MD. 31. Date filed (Month, Day, Tear) er's Signature State Registrar

		1	For State	Certificate of D		Reg	. No.	
			Registrar 1. Decedent's Name (First, Middle, Last)			Date of Death Month	Day Year	3. Time of Death
	Physiciar Medic	ol l	Marie Catherine O'Connor			June 18		11:15 PM
	Examine		4a. Facility Name (if not institution, give street and number) Riverview Care Center		Location of Death		4c. County of Death Baltimo	ore
	Funeral Director		5. Social Security Number 6. Sex 1 \(\text{ M 2 \(\)\text{XF}} \) 7. Age (in yrs. last 90	st birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Oct. 31, 1	9. Birthpl Counti 920 Mary	ace (State or Foreign y) vland
	show d at	. h	Tou. State	, Town or Location Essex			10	od. Inside City Limits 1 ☐ Yes 2X No
	Mary 28a-f notifie	.≞ L	Maryland Baltimore	10f. Zip Code		100	g. Citizen of What Count	
36	with the 23a or st be r	Funeral D	10e. Street and Number 308 Riverside Dr.		1221		USA	
	permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inpartment of Health and Mental Hygiene. Inpartment of Health and Mental Hygiene. are strong that them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Fun	11. Marital Status 1 Never Married 2 Married 3 No Widowed 4 Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: Whit	tc.
12-00	72 hours "natura edical E	Completed by	15, Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired)	during most of work	ing 1	6b. Kind of Business Ind	ustry
712	vithin jiene. er thar the N	Col	Elementary/Seconday (0-12) College (1-4 or 5+)	Homemake	r		Own Home	
pu	filed v tal Hyg d othe event,		17. Father's Name (First, Middle, Last)		18. Mother's Nam	ne (First, Middle, Ma Naric	iden Surname)	
ryla	uld be d Ment marke natic	욘	Dewey Chapman 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street			ity or Town, State, Zip C	ode)
Ma	2 sho ilth an 27 is i		Katherine Mary Wahl (Daughter)	308 Riversid	e Dr. Bal	timore, 1	Maryland 21	221
Baltimore, Maryland 21215-0036	Page 1 and lent of Hea nt: If item ry or othe		20a. Method of Disposition	Place of Disposition (Name of emetery, crematory or other pla rdens of Faith	June	22,201	Oc. Location - City or To	
Balti	permit, F Departm Importa any inju		21. Signature of Funeral Service Lipensee	22. Name and Addre Bruzdzins	ess of Facility Ki Funera Fastern A	l Home P	.A. sex, Maryla	nd 21221
) Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death chock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of the condition of the condition resulting in death)	h. Do not enter the mode of dyii	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
À		iner	Sequentially list conditions, if any, leading to immediate aucs. Enter Unidentifies Due to (or as a consequence of the conseq	consequence of):				
).p.	e executec cian and vurial-trans	al Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of the	uence of):				
760	cate b physic	ledical	d					
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnat 1 ☐ Live Birth 2 ☐ Fett 4 ☐ Pregnant at time of 0 9 ☐ Unknown	al death 3 🗀 Ectopic pregnar	ncy		23d. Date of deliv Month	ery Day Year
s, P.O.	es that the signed by t t be detach		Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause g	given in Part I.		acco use contribute to t	
of Vital Records,	law requir has been ge 2 should	Completed by	Deep Venous Throm	20015		24a. Was ar autops perform	y prior to co	psy findings available ompletion of cause of
R	ificate or, pag		25. Was case referred to medical	26.	Place of Death (Che	1 🗆 Yes 2 ck only one)	ZIA NO	2 110
Vita	ysicia iis cert direct	To Be	examiner? 1 Yes 2 X No Hospital: 1 Inpatient 2	ER/Outpatient 3 L DOA			nce 6 Other (Specif	y)
of \	ling Ph n. After th funeral		27. Manner of Death 1 🔀 Natural 5 🗆 Pending (Month, Day, Year)	28b. Time of 28c. Inju wo	ury at ork? ☐ Yes 2	28d. Describe ho	w injury occurred	
Division	or Attendafter deatl Director: in by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At h building, etc. (Specification)	nome, farm, street, factory, office fy)	=	28f. Location (Str City or Town	reet and Number or Rura , State)	il Route Number,
Ω	Hospital 24 hours Funeral eted filled	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examinatic only one) 3 Certifying Nurse Practioner: To the best of my					
_	To the within To the compl-	Σ	29b. Signature and title of certifier		nse number	2	9d. Date signed (Month,	Day, Year)
	3		30. Name and address of person who completed cause of death (Iter	m 23a) (Type, Print)		u Rocard		21061
	Sta	ate	31. Date filed (North, Par Year) 32. Registrar's Sign			J. Joseph		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien® \(\Omega\) Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 2011 11, 2:30 P. June Ouyang Keging /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Dayton 15154 Sapling Ridge Drive Social Security Number 6. Sex 7. A Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In vrs. last birthday) **Funeral** Hours Days Months 1**X**□**X**M 2□ F China 06-14-1922 89 156-98-4752 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 1 and 2 should be filed within 72 hours after death with the Marylan Heath and Mental Hygtene.
tem 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, I'm "sedical Exprine runal by notified at 1 ☐ Yes 2 No Dayton Director Howard MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21036 15154 Sapling Ridge Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify ģ Asian 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Ouyang Yucan Deng (unavailable) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15154 Sapling Ridge Dr., Dayton, Maryland 21036 permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra once. Feng Ouyang - son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 06-17-2011 Glen Burnie, Maryland Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signatule of Funeral Service I MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hears **Physician** Chimic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of) attending physician for use as the burial Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No P.0. 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown icate has been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No certificate 1 ☐ Yes 1 □Yes or Attending Physician: 26. Place of Death (Check only one) 25. Was case re-examiner? director, Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1∐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2011 30. Name and address of be son who completed cause of death (Item 23a) (Type, Print) NUCTH OF COLUMNIA CHENG

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 Donna C. Oros June 15, 8:54P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8545 Horseshoe Lane Potomac Montgomery If Under 1 Year I If Under 24 Hrs. Social Security Number Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Feb. I, 1923 Days Min. 1 □ M 2 🛛 F New York Director 062-18-3403 88 Usual Residence of Decedent shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland | Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8545 Horseshoe Lane 20854 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: 3 X Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) uld be filed within Mental Hygiene. Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward J. Wilting Julia Thuman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Holly C. Oros/Daughter 8545 Horseshoe Lane, Potomac, Maryland Important: If iten 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 20 Cate of Heaven Cemetery 1 X Burial 2 Cremation 3 Removal from State 2011 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 22. Name and Address of Facility Robert A. Pumphrey Funeral Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 . Signature of Funeral Service Licensee Pumphrey Funeral Home, K0800M 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 2007-Present End Stage Dementia Medical Due to (or as a consequence of) Examiner Seizure Disorder Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or linjury that initiated events resulting in death) Last burial-transi Due to (or as a consequence of): nding physician use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month Dav Year 5 Other (specify) Pregnant at time of death signed by the all d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛛 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X N this certificate Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral 1 X Natural 5 Pending 1 Tes 2 🗌 No Investigation Accident 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License numbe

Registrar
DHMH 17 Rev 7/2009

State

30. Name and addre

31. Date filed (Month, Day, Year)

Mary Mécker, CRNP

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

s of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

R071879

1355 Piccard Drive, Rockville, Maryland

June 16, 2011

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Registrar

State of Maryland Department of Health and Mental Hygiene Certificate of Dooth Reg. Non 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ F. Oland, Sr. 23° William 20°1°1 6:45amM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brooke Grove Nursing Home Montgomery Sandy Spring Birthplace (State or Foreign Country)
 MD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days May 20 Year 1926 Hours Min. 1 X M 2 🗆 Months 84 MD Yrs Director 218-30-4084 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edittal Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits hours after death with the Maryland Director 1 Yes 2 X No Montgomery Brookeville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20833 USA 3120 Damascus Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify 3 XWidowed 4 ☐ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) agriculture farmer Be 18. Mother's Name *(First, Middle, Maiden Surname)* Ella L. Royer 17. Father's Name (First, Middle, Last) Fred David Oland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14101 Parkvale Rd., Rockville, MD 20853 Cathy Frager (daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Mt. Carmel Cemetery Sunshine, MD 4-27-11 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee MO0764 Sykesville, MD 21784 Box 195. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PNEWMONIA disease or condition Medical resulting in death) Examiner AS PURATION Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of Cause (Disease or iinjury that initiated events use as the burial-trar CERTIFICATIONAPP Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Įo, Day Month Year Pregnant at time of death 9 Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No certificate Yes 2 completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) iner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t Certificate: 1 X Natural 5 Pending 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a Certifier 🛮 📉 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and plane, and due to the causely) and manner as states 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number COURT, SUME LOD, ORNEY MM 20832 30. Name and address of person who ompleted cause of death (Item 23a) (Type, Print)

Registrar

State

3416 OLAND WOOD

32. Registrar's Signature

TREPSON, MM

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>011</u> Physician/ Month 03:30 AM Irmgard Otero 16 J<u>une</u> Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Timonium Baltimore Co. Stella Maris Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 🗆 M 2 💢 F Hours Country) 03/12/1934 217-56-4448 77 Germany Director Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Baltimore Co. Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21093 2300 Dulaney Valley Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married than "natural", or þ Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. If Yes, Give Completed 3 Widowed 4X Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 3:30 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Registered Nurse 3 yrs and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2011 ၉ Anna Baumer Ro1ph Grosse-Bley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau JUNE 16, Glen Burnie, MD Mrs. Angela P. Mueller /daughter 103 Mark Drive 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 6/17/2011 Glen Burnie, MD 4 Donation 5 Other (Specify) Atlantic Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) sician and burial-transit Exami Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 Month Vear Pregnant at time of death Yes 2 X No 9 Unknown 9 🗌 Unknown After this certificate has been signed by funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 X Probably 4 ☐ Unknown 1 Tes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗶 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred X Natural iniury 5 Pending Accident
Suicide Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and accress of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 7/2009

State Registrar

FRMGARD OTERO

32. Registran Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month PM **Physician** LOIL 4a. Facility Name (If not institution, give street and number) /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore City The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) [0/5]1944 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 212-46-8086 $\varphi \varphi$ Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 28a-f show must be notified at 1XYes 2 □ No Director saltimore 10g. Citizen of What Country? 10e. Street and Number items 23a or USA 21205 -Son Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Maryland 21215-0036 Specify: ò 4 Divorced ò 3
Widowed Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Krivate Contractor TRUC K Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) f Health and Mental F tem 27 is marked of Park Jessie Magnus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21205 Ave. Baltimore, MD 2637 Ashland Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other pla : If item 20a. Method of Disposition

1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) þ 6/25/2011 Randallstown MD Department o Important: If any injury or once. March F/H 1101 E. North 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Solun Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed g physician and as the burial-transit Due to (or as a consequence of) resulting in death) Last Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 2 No 1 🗌 Yes 3 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2 25. Was case referred to medical 26. Place of Death (Check only one, Be Hospital: 1 1 Inpatient Other: $_{4} \square$ Nursing Home 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ပ္ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: within 24 hours after death. To the Funeral Director: After Injury 1X Natural Pending investigation 1 🗌 Yes 2 □ No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and little of 29c. License number RES-000 June 16 30. Name and address o person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **JYYY**E A^M Parr 20 2011 George Theodore 35 Medical or Location of Death 4c. County of Death BALTIMORE 4a. Facility Name (if not institution, give street and number)
ST JOSEPH MEDICAL CENTER 4b. City, Town, or I Examiner 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Numbe . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sex 1 X M 2 □ F **Funeral** Days Jan 31, Year 919 Months Hours 219-07-9105 **Director** Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State death with the Maryland Director 1 Yes 2 X No Baltimore Towson Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò iral", or items 23a or Examiner must be i Funeral 21286 U.S.A. 211 Garden Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 X Yes 2 □ No Black, White, etc. by 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: Year or Dates 1942–1945 White 3 X Widowed 4 Divorced Completed Ith and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical." 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Oil Company 12 years Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked o any injury or other traumatic eve ၉ George Adam Parr Barbara Helen Nengel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pennsylvania 17603 Lancaster, George J. Parr (son) Spencer Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6-23-11 New Cathedral Cemetery Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland Fen 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final SEPSIS Approximate Interval Between Onset and Death Immediate Cause (Final Phylician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events and I-transit Exami The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a sthe burial-Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE 23e. Did tobacco use contribute to the cause of death? } Q 2 No 3 Probably 4 Unknown 1 Tes Completed page 2 should CONGESTIVE HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗶 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at work?
1 \sum Yes 28a. Date of injury 28b. Time of 28d. Describe how injury occurred

Box 68760 P.O. Division of Vital Records, Hospital or Attending

State

Certificate:

Medical

1 X Natural

☐ Accident ☐ Suicide

4 Homicide

29a. Certifier

(Check

3 🗌

29b. Signature and title of certifie

5 Pending

Investigation 6 Could not be

determined

29c. License numbe D24034

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 🗆 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 2011 0

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Month, Day, Year)

mpleted cause of death (Item 234) (Type, Print)
M.D. 7601 OSLER DRIVE TOWSON, MD 21204 TIMOTHY LOW,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) 32. Regis rar's Signature 2011 IIIN 2 1

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death ^D2011 Physician/ 5:05 P M June 18 Gladys Geneva Parks Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Bel Air Upper Chesapeake Medical Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 □X 1928 Virginia Director 225-30-6741 83 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Harford 1 Yes 2 No Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21154 USA 3714 Bav Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2X No 1 Yes 2 No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Silk Screener Sign Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Florence Gurtrude Carter David Silvester Overbay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3714 Bay Road, Street, Maryland 21154 Sandra Hamilton / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Bel Air Memorial Gdn 6-22-2011 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. Signature of Funeral Service Livensee athleens 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician NIMM disease or condition resulting in death) Medical Due to (or as a con le uence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Certificate: To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 mor Pregnant at time of death 2 No Unknown 9 Unknown conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to 26. Place of Death (Check only one) examiner? Other: 1 Tes 1 🖪 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne 28c. Injury at work? 1 Yes eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Director: After Natural 5 Pending 2 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death tem 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ D2011 June 17, Dorothy Connolly Peters 6:10 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Stella Maris Hospice Timonium If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Aug 18, 1 **Funeral** Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 M 2 X F Country) Maryland Director 214-22-2492 84 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Timonium 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2525 Pot Spring Road, S432 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ Black, White, etc. 1 Never Married 2 X Married Yes 2 X No 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker n/a Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Connolly <u>Josephine</u> Eisel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Edward F. Peters, Jr./Husband 2525 Pot Spring Road, S432, Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/20/2011 cemetery, crematory or other place) Dulaney Valley Memorial Gardens Timonium, Maryland n W. Clary 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Onset and Death Ph_sician/ END STAGE RENAL DISEASE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) 2011

Registrar
DHMH 17 Rev 7/2009

State

JACKIE JONES,

a.m.

01:9

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

person who completed cause of death (Item 23a) (Type, Print)

CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death
__Month 3. Time of Death **Physician** acqueling une 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Manor Care Ruxton Towson If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Sept 27 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Mary Land Days Hours Min 1 □ M 2 N □ F 86 Sept 1924 220-14-8445 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Movical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director MD. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 USA 1024 Marleigh Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🙀 No <u>م</u> Specify White 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hospital Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cecelia unknown William Ε. Tavlor ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jerry T. Lambdin/ Attorney 427 A. Eastern Blvd. Baltimore, MD. 21221 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, MD. Dulaney Valley Mem. 6-23-11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. neral Sgrvice Lic o ee 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** day Dementic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ģ Month Day Year 5 Other (specify) the detached n signed by the ld be detach€ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 s autopsy performed? 1 ☐ Yes 2 No ₽ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier time certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29b. Signature and title of certifier ss of person who completed cause of death (Item 2001) (Type, Print) Bellona lone, Towson, MD 21204 M.D nchard 31. Date filed (Month Pay Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death - State Registra 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 2011 14:43 June 18. Physician/ Peltzer, Jr. Howard Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Carrol1 Westminster Carroll Hospital Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number (Month, Day Yes -20-1925 **Funeral** Months 1 XM 2 □ F 86 218-16-1848 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County Director 1 Yes 2XX No permit, Page 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-fs any injury or other traumatic event, the Medical Examiner must be notified. Boring MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States Funeral 21020 14823 Old Hanover Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc 11. Marital Status Armed Forces 1 ☐ Yes 2 🗓 No If Yes, Give 1 Never Married 2 X Married þ ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 White 3 Widowed 4 Divorced Year or Dates ted 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Complet Harry T. Campbell College (1-4 or 5+) Elementary/Seconday (0-12) Company Office Manager 12 years 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Blanche W. Martin James Howard Peltzer, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14823 Old Hanover Rd. Boring, MD 21020 Evelyn M. Peltzer (wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Finksburg, MD 6-22-2011 Evergreen Mem. Gar. → Sther (Specify) 4 Donation 22. Name and Address of Facility ELINE FUNERAL HOME of Funeral Se 21. Signat MD 21136 11824 Reisterstown Rd. Reisterstown, Wayne Osterling 23a. art 1 Inter the Usease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Shoc Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a con-Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examiner 5 attending physician and I for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 Ctopic pregnancy 5 Other (specify) 23b. Was decedent pregnant Month Year in the past 12 month Pregnant at time of death 2 10 Unknown cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Propably 4 ☐ Unknown þ Completed Were autopsy findings available prior to completion of cause of death? 1 Yes 2 Ne 24a. Was an 24b. autopsy performed^a 26. Place of Death (Check only one, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify

To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 certificate funeral director, မ this s after death. Certificate: filled in by the within 24 hours after de To the Funeral Director completed filled in by t

2 No 1 Yes 27. Manner of Death Natural

Accident

2 Accident

29a. Certifier

29b. Signat

(Check

4 Homicide

5 Pending Investigation Could not be

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)
06-20-20|

Went minter MD 211577 B. Kaneue 34 ype, Print)

State Registrar

Medical

31. Date filed (Month, Day, Year)

determined

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 June 17. 5:05 Frederick William Parks A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Montgomery Hospice Casey House Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Min. 1 X M 2 □ F Hours April 26, **Director** 218-16-0299 88 Washington, D.C. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 337 Seth Place 20850 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 2 No WWII 1 Never Married 2 Married ğ 1 X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Korea Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Mechanic/Heavy Equipment Operator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Estelle Rose Carroll Frederick Schaffer Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23705 Eli Lane, Gaithersburg, Maryland 20882 Claressa E. Hashmall/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) June 23, 2011 Parklawn Memorial Park Rockville, Maryland 21. Signature of Funeral Service L Robert A. Pumphrey Funeral Home, Rockville, 300 W. Montgomery Ave., Rockville, Maryland 20850 M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ Pyelonephritis disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Bladder Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death signed by the a d be detached f Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown has been si e 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page performed? Yes 2 X No certificate | 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Ves 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral dir 4 □ Nursing Home 5 □ Residence 6 🕅 Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 🗌 Yes 2 🗆 No XNatural Accident 5 Pending М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10x1 D0060634 June 17, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 6001 Muncaster Mill Road, Rockville, Maryland 20855

M.D

Bindu Joseph,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day PRIPSTEIN SYLVLA 2011 06 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD LORIEN COLUMBIA COLUMBIA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2X F Months Days Hours Min. Director 213-20-2901 86 08/15/1924 MD Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shoot Ite Western Examination of Director 1 ☐ Yes 2X No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3403 FIELDING ROAD 21208 Funeral USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian. Was Decedo... Armed Forces? 1 □Yes 2 XNo Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: ੬ Specify: 3 XWidowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 12 should be filed what and Mental Hygien is marked other the ACCOUNTING STATIONERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BENJAMIN ဂ္ HARTZ BLANCHE BERMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 si Department of Health an Important: If item 27 is 1 any injury or other trau SAMUEL PRIPSTEIN/SON 6125 ENCOUNTER ROW, COLUMBIA, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARLINGTON CHIZUK
AMUNO CEMETERY 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/20/2011 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Marle 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LONGESTIVE **Physician** DAYS > MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed CARDIOMYOPATHY and Due to (or as a consequence of) burial-Box 68760, physician Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) P.0. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy HYPERTENSI performed certificate 1 □Yes 2 ☑ No Division of Vital 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No Nursing Home 5 Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After _1 → Natural 5 Pending n 24 hours atter death.

le Funeral Director: Af pletely filled in by the ful 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

COLUMBIA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LORIEN

32. Registrar's Signature

LANE

CEDAR

2011

31. Date filed (Month, Day, Year)

00069962

21044

18/2011

11-04446	
Olivia Ryles	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Olivia Ryles	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No.	19701
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	Time of Death
Site -	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth	
Funeral	1721 N. Durham Avenue Baltimore N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthpla	oco /Stato or
Director	220-12-6948 1 Months Days Hours Min. 2/26/1928 Foreign Country	
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c.	d. Inside City Limits
	Baltimore	Yes 2 No
or 28a-i ied at g	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
leath with the Maryland ritems 23s or 28s-f sh tust be notified at one uneral Director	1721 N. Durham Street 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	Indian, Black,
or death or item		,
ural", miner		ack
5 72 hou na "nat sal Exa	Elementary/Secondary (0-12) College (1-4 or 5+)	-
5-0036 ed within 72 hours aftigiene. other than "natural" the Medical Examine Completed by	9th N/A Machine Operator Esskay Mea 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	t Co.
215- be filed natal Hyg rked off	John H. Lewis Green	
D 21 should and Mer 7 is man	11100 Bolton St Ant 1410 Bolton	
e, M 1 and 2 Health item 2 r trans	200 Method of Disposition (None of Company)	n, State
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot injury or other tranmatic event, the Medical Examiner must be notified at once. To Be Completed by Furneral Director		North
Physician /Medical		oproximate Interval etween Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Cardiovascular Disease Due to (or as a consequence of):	Death
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Division o spital or Attending ours after death. neral Director: After filled in by the fune	2 Accident Investigation 3 Suicide 6 Could not be Could n	oute Number, City
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To the Hos within 24 h To the Fur completely	Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated.	ise(s)
Z 2 2 3 Z		ay, Year)
	O.C.M.E. June 20, 2011	
V	30. Name and/address of person who completed cause of death/(Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registrar		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 19 2011 11:30 A M June Raymond S. Romanick Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>18805</u> Briars Court Olney Montgomery If Under 1 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months 1 🛛 M 2 🗆 F Days Min. 1<u>936</u> Pennsylvania Director <u>211–28–4000</u> 74 Aug Usual Residence of Decedent show 10a. State with the Maryland items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Olney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20832 18805 Briars Court United States filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner ō þ 1 Never Married 2 X Married X Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Completed 3 Widowed 4 Divorced Year or Dates:1954–1962 White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Federal Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) marked မ Ignatius Romanick Mary Husla permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara J. Romanick / Wife 18805 Briars Ct. Olney, MD 20832 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 6/21/2011 Woodbine, Maryland Signa in of Funeral Service Licen ^{22.} Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician Cerebrovascular Accident disease or condition resulting in death) Medicar Examiner Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Unknown 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate Yes 2 🛛 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes Hospital 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 5 Pending ☐ Accident☐ Suicide Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) June 20, 2011 D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coleman 1355 Piccard Dr. Ste. 100 Rockville, MD 20850 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No 3. Time of Death **5:/5 A**, M 2. Date of Death I. Decedent's Name (First, Middle, Last) Physician/ Time Gladys Lona Ruley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Anne Arundel Glen Burnie If Under 1 Year | If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 218 22 9940 82 Director Nov.10,1928 Florida Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 22 any injury or other traumatic event. the Natural 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 🗌 Yes 2 🔀 No Maryland Anne Arundel Millersville 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 8292 Brookwood Rd. 21108 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates White Completed 3 → Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electronic Technician Westinghouse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Riley Harrison Rebecca Jordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith A. Longerbeam (Daughter) 1003 Meadow Glen Rd. Baltimore, Maryland 21220 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gardens 6/24/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) ^{22. Name and Address of Facility} Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex Funeral Service Lice Maryland 21221 23a (Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cong ESTIVE Physician/ disease or condition Medical resulting in death) DUFAF **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? certificate has been signed by the atteriector, page 2 should be detached for Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: Certificate: To 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28c. Injury at work? 1 \square Yes Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending 2 No Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 24 hours after death.

Funeral Director: After thi leted filled in by the funeral

> 10 State

only one)

29b. Signature and title o

30. Name and address of

Verson who completed cause

DHMH 17 Rev 7/2009

29c. License number

n Burline

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:55 AM Physician/ Month June 17, 201 James Edward Ruane Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Golden Living Center-Westminister Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** Days Hours 1 X M 2 □ F Months Min. (Month, Day, Year) 77 Country Maryland 219-32-5628 1934 Director Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No MD Carroll Westminster 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States other than "natural", or items 23 vent, the Medical Examiner must 1234 Washington Rd. 21157 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ò 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 1955 - 50 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specity only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Printing Paper Cutter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental H 7 is marked of မ William A. Ruane Clementine V. Heyne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Ruane /Brother permit. Page 1 and 2 s Department of Health 3406 Farmstead Dr. Westminster, MD 21157 Important: If item 27 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Jun 20 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland Chesapeake Crematory 2011 injury 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Cremation and Funeral Alternatives MO1585 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition KINSONS Severe Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death). Due to (or as a consequence of) Exami The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown be detached 9 Unknown P.0. signed by Part II. Oth<mark>er significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available 24a. Was an page 2 s autopsy performed? Yes 2 No prior to completion of cause of death? has 2 1 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred ☑ Natural 5 Pending Division 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) sels X 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) Honer

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month. Day. Year

32. Registrar's Signature

backs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Martha Ritterstein June 2:45 PM 2011 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE **Examiner** RANDALLSTOWN SEASONS HOSPICE Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) JUNE 4,1915 Days Hours 1 □ M XXF Country) SLOVAKIA 213-60-2332 **Director** 96 Yrs. Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits than "natural", or items 23a or 28a-f sho he Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 XX MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 4730 ATRIUM COURT APT. 367 21117 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. 1 \square Never Married 2 \square Married 1 ☐ Yes 2XXNo Specify: Specify: 3 XXVidowed 4 □ Divorced Completed WHITE pernit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) HOPKINS UNIFORM Elementary/Seconday (0-12) BOOKKEEPER COMPANY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ KOLOMAN **GYARMAT** ADELA JUNG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $3719\ THOROUGHBRED\ LA$, OWINGS MILLS, MD 21117PETER RITTERSTEIN/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XXIII 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 6/20/2011 CHEVRA AHAVAS CHESED : RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee May Co 8900 REISTERSTOWN RD, BALTIMORE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. terval Betweer Onset and Death Immediate Cause (Final End-Stage Cardiomy opany Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 No ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pendina 2 Accident
3 Suicide
4 Homicide Investigation Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 DCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MS RiyapalizeM.D D0057465 6/17/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21709 Baltimore N.S. Rajapakse, MID 2835 Smith AV 5-703 31. Date filed (Month, Day, Ye JUN 2 1 2011 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 2011 8:30 A M Jeffrey Rodney Swope Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia 9345 Windbell Way Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 □ F Hours Apr 17, Year) 945 Pennsylvania Director 176-34-3772 66 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 X No Columbia <u>Maryland</u> _Howard 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 9345 Windbell Way 21045 ral", or items 2 death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc þ 1 Never Married 2 X Married X Yes be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 🗌 Widowed 4 🗆 Divorced Specify: White Completed Year or Dates 1963-1966 if Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical School 12 Medical Photographer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Dorothy Louise Zinn Samuel Franklin Swope Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9345 Windbell Way Columbia, MD 21045 Donna R. Swope / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once. 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 6/22/2011 Woodbine, Maryland 21. Signature of Funeral Se Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 13 months Physician/ Metastatic Adenocarcinoma of Unknown Primary disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth
Pregnant a
Unknown 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 🔀 No certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No Other: ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28c. Injury at work? 1 □ Yes 2 □ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending injury 1 X Natural 5 Pending 2 Accident
3 Suicide death. Investigation 24 hours after deat Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

12

Registrar

DHMH 17 Rev 7/2009

State

Date filed (Month, Day,

JUN 2 1 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward Lee 10710 Charter Dr. Ste. G020

32. Registrar's Signature

D23601

G020 Columbia, MD 21044

June 20, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SHARPE Physician/ Otto 11:32 AM Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mandrin House Anne Arundel Harwood Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Days Hours Min 12 1941 Mary land Director 218-76-4613 69 Aug Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Severn ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ian "natural", or items 23a or Medical Examiner must be Funeral 1357 Jamestown Drive 21144 United States death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give 1 X Never Married 2 ☐ Married ģ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry ould be modnd Mental Hygiene. s marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Non-profit Organization Volunteer Be 17. Father's Name (First, Middle, Last) th and Mental h 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur Sharpe Evelvn Purinton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra <u>Cherry P. Chapin / Cousin</u> 1199 Summit Dr. Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 6/22/2011 Woodbine, Maryland 21. Signal of Funeral Service L Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Immediate Cause (Final END Physician/ 947 WTH'S STAGE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): ending physician a use as the burial-Physician/Medical Box 68760 use as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery atter for u in the past 12 months?
1 ☐ Yes 2 ☐ No Day the 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown certificate has been sirector, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending injury Accident Investigation M 1 Yes 2 No after death the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Funeral L Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 horonic to the total for the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL State Registrar

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

4b. City, Town, or Location of Death

2. Date of Death

June 20,

^D2011

4c. County of Death

Certificate of Death

3. Time of Death

1:05 P

For State Registrar

Constance

Physician/

Medical

Decedent's Name (First, Middle, Last)

4a. Facility Name (if not institution, give street and number)

Josephine Stotsky

Examiner Heritage Nursing Center Dundalk Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 😿 F 081-14-4887 0470971923 New York Director 88 Usual Residence of Decedent 10c. City, Town or Location Middle River ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. Count 10d Inside City Limits Director Baltimore Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7508 Schooner Lane 21220 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 XNo Specify Specify. White 3 Midowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Warehouse permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Augustus Bush Theda Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Kosoak Road, Baltimore, Maryland 21220 Debrha Pastore (Niece) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Oak Lawn Cemetery 06/25/2011 Baltimore, Maryland Signature of Funeral Service Livensee 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Epische disease, or complications that caused shock of heart failure. List only one cause on each line. Immediate Cause (Final or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwe CARDIO-NASCULAR DISEASA Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery Ectopic pregnancy in the past 12 months' 1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 🗌 Yes 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?

1
Yes 2
No 24a, Was an page 2 certificate has 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 2 🗌 No ☐ Accident Investigation completed filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 110 death (Item 23a) (The, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Elizabeth Margaret Shamleffer 916 AMM 06 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Roseda Himore Franklin Hospita are 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Ye Country) 74 213 34 1946 **Director** Aug. 24, 1936 Maryland Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Maryland Baltimore Essex 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 "natural", or items 23a o edical Examiner must be Funeral 21221 USA 13117 Miles Rd. Shamletter, tlizabeth Baltimore, Maryland 21215-0036 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ White 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: Completed Year or Dates. permit, Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medicall once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Avon - Cosmetics Salesperson Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Michael A. Wagner Sr. Elizabeth Weidel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phylis A. Seman (Daughter) 2243 Schuster Rd. Jarrettsville, Maryland 21084 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Most Holy Redeemer 6/22/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home P.A 1407 Old Fastern Avenue Esse Maryland 21221 23a Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Respiratory
Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine thany, leading to immedicause. Enter Underlying for use as the bunial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Year Pregnant at time of death detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 No Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 X No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 X LER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ▼ Natural 5 Pending work?
1 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide 6 Could not be . Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[Insert Section 2] Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier D0061663 06/19/2011 MD address of person who completed cause of death (Item 23a) (Type, Print) Q

State Registrar Jonathan

31. Date filed (Month, Day, Year)

2

Square Drive.

900 OFranklin

ack

32. Registrar's Signature

MD

Baltimore MD, 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June Montena 2011 3:30 P M Street Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 916 Wanda Road Linthicum Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕸 F Days Month, Day, Year, 1927 West Virginia Director 415-38-9280 83 Aug. Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Lansdowne 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Box 33 Carling 21227 USA Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes Give 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James C. Parrott Birdie E. Bare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 916 Wanda Road, Linthicum Maryland 21090 Paul E. Street Jr.-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) June 18,201 Brooklyn Park Maryland 22. Name and Address of Facility Ambrose Funeral Home Of Lansdowne Signature of Funeral Service Li U 2719 Hammonds Ferry Road, Lansdowne Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ carahoma year Medical resulting in death) Due to (or as a consequence of) **Examiner** Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Completed by Physician/Medical Examiner Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last To the the the death of the difficate be a virtue of the death of the death of the death of the death of the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia ☼ Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) ____ Day Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 - Nursing Home 5 - Residence 6 other (Specify) SCN) S PLSI dunie 1 🗆 Yes 2 💢 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred Natural Acciden Suicide iniury 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DAEETHA RAJA MD 18754 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GETHA RASA, 4367 HOMMS FLORY "Rd, Buite 4A, Baltimore, MD & 1227 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 1 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June D2011 17, 2:01 A Dolores Marie Szymanski Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 1734 Wycliffe Ave. Parkville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth
(Month, Day, Y
June 20, 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 M 2 KF Hours Director 215-24-0222 Yrs. 1929 81 Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 🖄 No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 1734 Wycliffe Avenue 21234 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married within 72 hours after If Yes, Give 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Blanche Stella Clark Mathias George Simon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1353 Trappe Road, Richard J. Szymanski Street, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corp. 4 Donation 5 Other (Specify) 6-18-11 Towson, Maryland Signature of Funeral Service Licensee McComas Funeral Home, P.A. Jachleen 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocarga disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner reroser Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: ses s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) Year be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician: The law has completed filled in by the funeral director, page 2 autopsy performe 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XResidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending *** atural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) of certifier 29b. Signature 29c, License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 09 13 A 2011 onna Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 500 Upper Chesapeake Se ctoca 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛛 F Months Days Hours Min August 16, 1944 ^{Country}yland **Director** 213-46-3367 66 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Harford Be1 Air Md. 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21014 956 Hillswood Road Apt.C 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 XMarried Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Accounting Clerk Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Howard Blevins Anna L. Shay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trai once, BelAir, Md. 21014 956 Hillswood Road Apt. C Charles D. Smith Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) St.Mary's Episcopal |6-21-2011 Abingdon, Md. 21. Signature of F 22. Name and Address of Facility 12. Name and Address of Facility Schimunek, Funeral Home 610 W. MacPhail Road Belair, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 L 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 0960 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 1 Yes Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) o 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖺 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Murse Prantioner: To the Sest of my knowledge d at the time data within 2 29b. Signature ar 29d. Date signed (Month, Day Year) 2011 no completed cause of death (Item 23a) (Type, Print) 30. Name and addle eto econ! 31. Date filed (Month, Day, Year, State Registrar

M800413569

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Jo II **Physician** Margaret N. Shinsky 4:30 AM June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center Baltimore N/A If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M MAY 6, 213-28-6264 80 MD. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 □ Yes 2 No Director GRACELAND PARK MD. BALTIMORE 10g. Citizen of What Country? 10e, Street and Number an "natural", or items 23a or Medical Examiner must be 514 S. 45TH STREET 21224 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZMNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " ent, the Med College (1-4or 5+) $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 10TH \end{array}$ SECRETARY **ESSKAY** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fil f Health and Mental H Item 27 Is marked oth other traumatic even Be HENRY BROWN REGINA DAUSCH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6909 DELVALE PLACE, BALTIMORE, MARYLAND 21222 JOE SHINSKY, III/SON permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 M Burial 2 □ Cremation 3 □ Removal from State GARDENS OF FAITH 06/22/2011 BALTIMORE, MARYLAND 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Onset and Death Immediate Cause (Final cardiac arrhythmia Physician 15 minute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner days ower gastroinlestingl Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknow þ signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy page performe performed? 1∐ Yes 2 Mo certificate I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 1 Natural 5 ☐ Pending investigation the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)

within 24

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 2 1 2011

Jennifer Cuhran, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29c. License number

RES - 000

4940 Eastern Avenue Baltimore, MD

June 18, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 19. Physician/ Mary Carol Stidham 2011 5:15 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dec. 9, 1937 1 M 2 XX Months Mary land 219-26-6187 73 Yrs **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 1 Yes XX No Maryland 1 4 1 Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number USA 36 South Pendleton Court 21703 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes Give 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Circuit Board Assemble 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Westington House Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Rita Batchly Jesse Kehler 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Stidham-Thompson 36 Pendleton Court, Frederick, Maryland 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🕱 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 6/21/2011 Glen Burnie, Maryland Signature Name and Address of Facility Burgee Henss Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland Pineral Service Licer 23a. Part 1. Enject the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Certificate: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death Yes 2 100 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 1 After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 LAG 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred work? (Month, Day, Year) injury 1 Natural 5 Pending M Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after To the Funeral Direc City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ESST SUIT 4105 BALTT MORE MD 2126 7

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1945 PM Louise Smith June 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Saint Agnes Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/25/1943 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Months 1 □ M 2 🗶 F 67. 218-44-0232 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f show 1 Des 2 No MD N/A Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1340 Argyle Ave. 21217 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 | Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ 3 Widowed 4 Divorced Black "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation item 27 is marked other than "natu other traumatic event, I'm Wedical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House Keeping Abacus 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Jenifer 2 Hattie Pumphrey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Louise Shaw(daughter) 2306 Kirk Ave., Baltimore, MD 21218 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or o once. 1 ☐ Buria! 2X Cremation 3 ☐ Removal from State on-site Crematory 06/14/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee fosepn Ades Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 23a. Payt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immiddiate Cause (Final disease or condition resulting in death)

a. End Stare rend disease or Condition resulting in death) Approximate
Interval Between
Onset and Death **Physician** /Medical Due to (or as a co equence of): Examiner Sequentially list conditions, if any leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant . 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) s been signed by the should be detached Division of Vital Records, P.O. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown HyperTension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 st autopsy performed? Yes 2 No 1 ☐ Yes 2 ☑ No Hypokalomia or Attending Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:

completely filled in by the I 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0068107 June 11, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 South Caton Avenue Baltimore, 31. Date filed (Month, Day, Year) State

Registrar

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Stolt 3 June 5:02 PM Medical 201 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death JMMC Shock Trauma Center Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F Days Hours (Month, Day, Country) Pennsylvania Director 168-76-2627 22 1989 March Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No PA Lancaster Gap 10e. Street and Number items 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 545 Cains Road 17527 USA Page 1 and 2 should be filed within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. δ 1 Never Married 2 X Married "natural", or Baltimore, Maryland 21215-0036 Yes 2 X No If Yes, Give Year or Dates 1 Yes 2 X No Specify. 3
Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 8 Construction Worker Precise Brothers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Christ S. Stoltzfus Barbara Stoltzfus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Mose D. Stoltzfus Father in Law 5433 Buena Vista Road Gap PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Millwood Cemetery 6/17/11 Gap ure of Fundal Servic Lensee 22. Name and Address of Facility ELINE FUNERAL HOME J. Wayne Osterling 11824 Reisterstown Rd. Reisterstown, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear failure. List only one cause on each line Interval Between Immediate Cause (Einal Onset and Death Physician/ Cerebral Herniatia disease or condition resulting in death) 6/10/11-6/14/1 Medical Due to (or as a consequence of): **Examiner** brain Trawmatic 6/10/11-6/14/ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) ng physician and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 CERTIFIC IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day 1 Yes 2 L 9 Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 1 Yes Yes 2 No s after death.

I Director: After this certific d in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner 1 Ves 2 No Hospital ဂ္ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 10:00AM Fall from 25 feet Accident 06/10/2011 Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Maryland House 24 hours a Chicken filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed file 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) mo P25607 6/14/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kalyon, 22 S. Greene Bilge Baltimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Physician/ Month Winifred Eleanor Sheridan June 12 11:50 A M Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Shady Grove Genesis Center Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Day 30 1 □ M 2 🛛 F Months Days Min Hours New York Director 073-07-4695 October 94 1916 Usual Residence of Decedent 28a-f show 10a. State with the Maryland notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛣 No Maryland Montgomery Silver Spring 10e. Street and Number ò 10g. Citizen of What Country? must be items 23a Funeral 1417 Crestridge Drive 20910 United States 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. P ☐ Yes 2 🔀 No þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 X No Specify Specify: White "natural", 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F ၉ Unknown Nora Tiller Page 1 and 2 should I ment of Health and Mc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Kathleen Rossignol / Daughter 15010 Plainfield Lane., Darnestown, Maryland 20874 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery |June 16, 2011 | Silver Spring, Maryland 4 Donation 5 Other (Specify) Signature of Fundal Signature of Signature o Robert A. Pumphrey Funeral Home, Rockville, M01619 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due o (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami burial-transit physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? for 4 ☐ Pregnant at time of death g ☐ Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Dementia 1 Yes 2 X No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? this certificate 1 Yes 2 X No 1 Yes 2 No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital 1 Tes 2 X No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: : After ! 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 \square Pending injury work?
1 Yes 2 🗌 No s after death Accident Investigation 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Hospital Medical Karage Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062435 June 13, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signature

Sayed Elsayyad, M.D. 10110 Molecular Drive., Rockville, Maryland 20850

State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ LENORA WALKER SCOTT 10:16A M JIINE. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 □ M 2 🛣 F Days Hours (Month Day, Year) 07/11/1922 NC 88 Director 237-34-1774 Usual Residence of Decedent items 23a or 28a-f show ier must be notified at 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7401 Willow Road Apt. A341 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give "natural", or item edical Examiner n 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: Completed 3 Widowed 4 X Divorced White Year or Dates er than "natur the Medical I 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) McCormick Spice Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha ury or other traumatic event, the 1 11 Quality Control Inspector Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pau1 Η. Walker Juanita Medford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Janet Hough / Niece 1925 Marlin Drive Ocean City, MD 21842 Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 106/17/2011 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW mallo Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ a reprovalative (ac disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) should be detached g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CEVIT Injan S 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page ? death? 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No မ 1 Tes 1. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pendina s after death. 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by determined City or Town, State Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 3 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 29c. License number ritin 1)09689 15 earra 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 West 9th Street 21701 Pearre Frederick, MD 1. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JUNE 2011 JOAN R SIEBERT 3:05 A M 16. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6173 MONROE AVENUE SYKESVILLE CARROLL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. Director 213-34-1934 74 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Me Ical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD CARROLL SYKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6173 MONROE AVENUE 21784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 SIMON GROTT FANNIE KELLERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains MICHAEL SIEBERT/SON 6173 MONROE AVENUE, SYKESVILLE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) HEBREW FRIENDSHIP CEM: 06/17/2011 BALTIMORE, MD 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ACUTE LEUKEMIA disease or condition Medical resulting in death) Examiner CHRONIC LYMPHOCYTIC LEUKEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that the death certificate be executed Cause (Disease or iinjury that initiated events INSULIN DEPENDENT DIABETES MELLITUS Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 Yes 2 No 9 Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2X No certificate 2 🗌 No 1 Tyes Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 💢 No Other: 1 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 XNatural iniurv work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nu/se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

of Vital

Division

BALTIMORE, MD

21208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MILAN WISTER,

4000 OLD COURT ROAD,

32. Pojistrar

06/16/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Items 25,28a-f per dr/me, 2916,06/10/2011dhb, 10e,f, 20a,b,c, per FB

Certificate of Death For State Registrar 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Day Physician/ -9. :30 PM 2-011 Medical 4a. Facility Name (if not institution, give street and humber, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7. Age (In yrs. last birthday) If Under 1 Date of Birth 9. Birthplace (State or Foreign Year Social Security Number 6. Sex **Funeral** Days 1 M M 2 D F Months Hours Min. Country) MD Director Usual Residence of Decede or 28a-f shov 10a. State 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County City, Town or Location **Funeral Director** 1 Yes 2 No MI timore 10f, Zip Code //AK 10e. Street and Number JAK 10g. Citizen of What Country? 4800 Seton Avenue 21215 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. / 95/ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20c Location - Gity or Town, State Crownsville, 20a. Method of Disposition Unit 20b. Place of Disposition (Name of VAK cemetery, crematory or other pla-1 X Burial 2 Cremation 3 Removal from State 03/16/2011 Crownsville 4 ☐ Donation 5 ☐ Other (Specify) Unerale 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RAVM disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): NCM SCHOUSTE attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): EXAMINER Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det þ 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy **Director:** After this certificate I 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 X No 1 Datural 2 Accident Subject was a pedestrian struck by a car. 5 Pending 11/30/2002 10:12 pM within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Painters Mill Rd.
R/R CSX 631 656 R, Owings Mill, Md 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **Roadway** determined Medical Prestifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month. Dav. Year) 29b. Signature and the of certific 29c. License number 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Georgia Lee Thompson 7:30 AM June 2011 Medical 4a. Facility-Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner ANNE ARUNDEI Baltimore Washington Medical Center Burnie Glen 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2XXF 231-54-8007 04/17/1943 68 MD **Director** Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fiem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Gambrills MD Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21054 USA 1698 Justin Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black. White, etc. 1 Never Married 2 Married þ White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Self-employed should be filed with and Mental Hygien is marked other th Be 17. Father's Name (First, Middle, Last)
George D. Kimble 18. Mother's Name (First, Middle, Maiden Surname) hampson, ဂ Lily E. Funk 19a. Informant's Name/Relationship (Type, Print)

Teresa Faircloth / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1698 Justin Dr., Gambrills, MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State W. Arundel Crematory 06/20/2011 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 le for M01452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on e. ch line. Approximate Interval Between et and Death Immediate Cause (Final Physician disease or condition ⊾ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months Month Day Year Pregnant at time of death
Unknown Yes 2 AM the 9 Unknown signed by the detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 ☐ Yes 2 ☐ Non 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 100 Hospital patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Atural work? 1 🔲 Yes 5 Pending Accident 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 0 who completed cause of death (Item 23a) (Type, Print) (portalu 2. Registrar's Signature State Registrar

5000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Angelo Maurice	Win	1- For State Registrar		of Maryland /	Departme Certifica			nd Ment	al Hygie		g. No.	C Community	19726
Physici Medical Exami	an/ ner	1. Decedent's Name (Fi		Maurice N	Winsto	n.Tr			l M	ate of Deat lonth I ne 14 , 2	Day	Year	3. Time of Death 1655 hrs
		4a. Facility Name (if not	institution, give				. City, Town, o Baltimore	r Location of		1110 14, 2		ounty of Death	
Funeral Director		5. Social Security Numb	er 6. Sex	7. Age (In yrs. last birth 26	day) Yrs.	If Under 1 Yes		_	Date of Birt		Foreig	thplace (State or in untry) MD
W Any		Usual Residence of Dec 10a. State 10b.	cedent County	10	Oc. City, Town o								10d. Inside City Limits
ne Maryland or 28a-f show fied at once,	Director	10e. Street and Number			Balti		10f. Zip Code			10	-	of What Coun	1 Yes 2 No
with the] ns 23a or be notifie	iral Di	713 Cat		12. Was Decedent Ev	ver in U.S.		2121 Decedent of Hi	spanic Origii			USZ 14	. Race - Americ	can Indian, Black,
after death ral", or iter	by Funeral		Divorced	f Yes, Give Year or Dates:	No No	1 Y	, specify Cuba	specify:				White, etc. Bla ecify:	
136 hin 72 hours e. than "natu	Completed	15. Decedent's Educat		chighest grade comple College (1-4 or 5+)	d		Usual Occupa t of working life ent			lone		d of Business/Ir d Scap	
21215-0036 vald be filed within 7 Mental Hygiene. marked other than it event, the Medica	Be	_	lo Wins					18.Mother's Eva	Name (Firs	t, Middle, M Simmo	aiden Sui DNS	rname)	
MD 21 od 2 should ulth and Mer m 27 is man	٩	19a. Informant's Name/F Evanda Si	Lmmons	^{pe, Print)} Mothe		713	Cator	Aven	ue Ba	alto	MD :		· ,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyggene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dispositi 1 Burial 2 X C 4 Donation 5	remation 3	Removal from State		y or other			Dat -6-23	2011	Hai	ation - City or 7	MD
		21 Signature of Funeral	Weal	atro						<u> </u>		<u> </u>	
Physician /Medical Examiner		23a. Part I. Enter the dis failure. List only on Immediate Cause (Final or condition resulting in	ne cause on each disease a. M		Wounds	enter the	mode or dying,	, such as car	diac or resp	iratory arre	st, snock,	or neart	Approximate Interval Between Onset and Death
ed nsit	Examiner	Sequentially list condition if any, leading to immedicause. Enter Underlying (Disease or injury that in events resulting in death	ons, biate Dug Cause ilitiated Dug Last Dug	ue to (or as a consequ ue to (or as a consequ	rence of):								
60, e be executed ysician and burial - transit	edical	UNPENDED	d	AMENDED				 .					
OX 6876 eath certificat eath certificat for use as the	Σl	IF FEMALE: 23b. Was decedent pregr past 12 months? 1 Yes 2 No 9	nant in the	23c. If yes, outcome of the Live birth 4 Pregnant at time 9 Unknown	2 [=	death 3	Ectopic p	pregnancy			ate of delivery inth Da	ay Year
ires that the direction by the detached	É	Part II. Other significan	t conditions c	ontributing to death bu	ut not resulting i	n the und	erlying cause (given in Part	I. 2				he cause of death? ably 4 Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deated.	Completed					_			— I	24a. Was ar autops perform ✓ Yes 2	y ned?		opsy findings available ompletion of cause of 2 No
Vital Re hysician: The this certificate	o Be (25. Was case referred to examiner? 1 ✓ Yes 2		spital: 1 Inpatient	2 ER/Out	patient 3		of Death (C			esidence	6 ✔ Other:	Scene
ion of V tending Phy eath. for: After the	-	27. Manner of Death 1 Natural 5	Pending Investigation	28a. Date of Injury (Month, Day Year) Jun 14, 2011	28b. Tii 1648 I	ne of Inju	y 28c. Inju	ry at Work? res 2 ✔ N	28d. l	Describe ho			
Division sspital or Attent hours after death hours after death neral Director: y filled in by the	Certification:	3 Suicide 6 4 ✓ Homicide	Could not be determined	28e. Place of Injury (Specify) Sidew		n, street, 1	actory, office b	ouilding, etc.		r Town, Sta	ite)	Number or Rura e, Baltimore, I	al Route Number, City
Divi	dical	one) 2 Medi	cal Examiner:0	: To the best of my kr n the basis of examina nd manner stated.									
	2	29b. Signature and title of	of certifier Hu	llan	-		29c. Licens O.C.I					signed (Mont 5, 2011	h, Day,Year)
W I		30. Name and address of Carol Allan, MD		npleted cause of death Medical Examin	. ,	. Baltim	ore Street,	Baltimore	e, MD 21	223			
Sta Regist	-	31. Date filed (Month, Da	y, Year) N 2 1 20	1.00	ignature	L	We!						
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			For State		State	of Maryla			ent of F ente of E		and N	lental Hy		201	Ī	10727	,
			Registrar 1. Decedent's Name	(First, Middle,	Last)			erunca	ite or L	Jean		2. Date of D	Reg. No	6. 01	rámaz	3. Time of Death	_
	Physicia Medic		Edward Ch									June 1	17 D	ay 20	1 ′1	6:26 P M	1
-	Examin	er	4a. Facility Name (if n						ty, Town, or DWSON	r Location of	of Death			c. County of D Baltim			
	Funeral Director		5. Social Security Nur 216–48–09	61	6. Sex 1 Д М 2 □ F	7. Age (In yrs) If Und Month	der 1 Year s Days	If Under Hours		8. Date of Bi		46 M	Birthpl	ace (State or Foreign and	n
	and show at	'n	Usual Residence of D 10a. State	Decedent 10b. County		10c. City, Town or Location								10	d. Inside City Limits	3	
	Maryla 28a-f otified	Director	Maryland	Harfo	rd	Da	rlingt	on					1 🗆			1 ☐ Yes 2 X N	0
	s 23a or ust be n	Funeral D	10e. Street and Numb		Road		10f. Zip Code 21034							itizen of Wha SA	t Count	ry?	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	اھ	11. Marital Status 1 Never Marrie 3 Widowed 4		12. Was Dece Atmed For ed 14 Yes If Yes, Giv Year or D	Forces? If ` as 2 \(\subseteq \text{No} \) Give 1			Was Decedent of Hispanic Origin? (Specify Yes or f Yes, specify Cuban, Mexican, Puerto Rican, etc. Yes 2 No Specify:				14. Race - Ame Black, Whit Specify: Wh		Vhite, et	c.	
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212	within giene. er tha	Elementary/Seconday (0-12) College (1-4 or 5+) Computer Security Specialist Federal Government											rnment				
Maryland 21215-0036	and 2 should be filed Health and Mental Hy tem 27 is marked oth other traumatic event	To Be	17. Father's Name (File Edward Cha		,	· _						ne (First, Middle, Maiden Surname) Eler Halliday					
Man	should hand hand hand hand hand hand hand the manumaturan		19a. Informant's Nam				- 1					l Route Numb					
e,	of Healt of Healt if item 2		Judith Wi	sition		20b.	Place of Dis	position (N	ame of			arlingt Date		Mary L ocation - Cit			_
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Balt	permit Depart Impor any in		21. Sign yur of Fund	eral Service Li		NÓLAC	77			ss of Facilit	110	Comas I	Tune:	ral Ho	me,	P.A.	
		Н	23a. Part 1. Enter the	e disease, or o	Dasir.	caused the de					_	d, Abir r respiratory a				Approximate	Ť
	Physician		Immediate Cause (Fi disease or condition	inal	a lu	Ltalla	Lac	Pre	estat	to (min	Can				Interval Between Onset and Death	
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	executed an and rial-transit	Examine	Cause (Disease or iir that initiated events resulting in death) La	njury	c. Due to	(or as a conse	quence of):								+		_
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. Box 68760	The law requires that the death certificate be attending bhysici atte has been signed by the attending physici page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 1 9 Unknown	onths?		Birth 2 🗀 Fe nant at time o	tal death 3	☐ Ectopi		рy		23d. Date o				y Day Year	
P.O.	that the de ned by the e detached	by Ph	Part II. Other signific	ant condition	ns contributing to d	eath but not re	esulting in the	underlyin	g cause giv	ven in Part I	ì.	23e. Did	tobacco	use contribut	e to the	cause of death?	
rds,	v requires that s been signed k should be det											1 🗆	Yes 2	□ No 3 [Proba	ably 4 Dunknow	n
Division of Vital Records,	sician: The law n certificate has b lirector, page 2 st	Completed										24a, Was auto perf 1 \(\sum \) Yes	opsy ormed?	prior deat	to com	sy findings available pletion of cause of	
/ital	sician; certifi irector,	m	25. Was case referred examiner? 1 ☐ Yes 2 ☐		Hospital:		7 5D (0)		Othe	ace of Deat				5/		11010 10	
J o	ng Phy ter this neral d	te: To	27. Manner of Death	5 Pending	28a. Date	Inpatient 2 L of injury th, Day, Year)	28b. Time injury	of	28c. Injury work	y at		me 5 Res 28d. Describe			pecify)	Hexpi C	<u> </u>
sion	ttendir death. tor: Af	Certificate:	2 Accident 3 Suicide	Investiga 6 Could n	etion ot be	of Injury - At I		М	1 🗆	Yes 2 🗍	-	006 1	(0)				
Divis	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certifica completed filled in by the funeral director;		4 Homicide	determi	buildi	ng, etc. (Speci	ify)					28f. Location (City or To	wn, State	*)			
>	re Hosp n 24 ho e Fune pleted f	Medical	(Check 2 L	Medical Ex	Physician: To the b caminer: On the bas Mary, Prection or	sis of examinati	on and/or inve	estigation, i	n my opinic	on, death oc	curred at	the time, date	and place	e, and due to	he caus	e(s) and manner stat	ed.
	To th Within		29b. Signature and tit		1-		CIA		9c. License					ate s/gned (///			
			30. Name and addres	Spa	be completed as	o of death in	m 92a) (T	Dwi-4\	DE	7104	-0		6	1/8/1	1.		_
14	11		and the formation of	S OF PARSON W	R -670	1 10	9440	IEC	ST	Suir	2/1	105	BA	TIMOR	G	MD 2120	4
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	1	State of Maryland / D. State of Maryland / D. State Amend Item 25 per me, g916, 9	epa Cert	ificate of D	eath	riental Hyg	giene Reg. No.?	19728						
Physician /Medical		Decedent's Name (First, Middle, Last)		all 5		2. Date of Dea Month	Day Yea 2 1 2 0 1 4c. County of De	1 1337						
Examiner	1	a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital Social Security Number 6. Sex 7. Age (In yrs. last birth)	nday)	Baltimore If Under 1 Year	City If Under 24 Hrs.	8. Date of Birth	h 9. E	N/A Birthplace (State or Foreign Country)						
Funeral Director	1	217-54-0830	or Loc		Hours Min.), 1949	So. Carolina 10d. Inside City Limits 1 📉 Yes 2 🗆 No						
natural", or items 23a or 28a-f show dical Examiner must be notified at et al. The control of th		Maryland Baltimore City 10e. Street and Number 29 South Hilton Street		10f. Zip-Code	21229		10g. Citizen of What	Country?						
"natural", or items 23a or 28a-f s idical Examiner must be notified leted by Funeral Director		1. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Vas Decedent of His f Yes, specify Cubar ☐ Yes 2 1xx No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ai Black, W Specify:	merican Indian, hite, etc. Black						
than " le Mec	Inpleted	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give .	lent's Usual Occupa kind of work done o DO NOT use retired) Glass	luring most of worl	king	16b. Kind of Busine Carr-Lowery	ess/Industry / Glass Company						
工事三	, ב <u>י</u>	7. Father's Name (First, Middle, Last) . John H. Green			_	El	, Maiden Surname) lan Green							
of Health and Mental It fitem 27 Is marked of r other traumatic ever	1	9a. Informant's Name/Relationship (Type. Print) Dollie Truesdale		-		altimore, M	er, City or Town, State aryland 21223							
	1	1 🕱 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	y, crer oud	sition (Name of natory or other place on Park Ceme 2. Name and Address	etery	Date 06/01/11	20c. Location - City Baltir	nore, Md.						
Department Important: I any injury o once.	ij.	21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Dorr shock, or heart failure. List only one cause on each line.	1	Estep B	rothers Fune	eral Service, altimore, M	P. A. d 21217 arrest,	Approximate						
ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit and page 2.	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of the condition of the consequence of the condition of the	of):	anial	hemou	TION MPROVED	e 1-//	Onset and Death						
ed by the attending phy detached for use as the Apple of the asset the Apple of the	Φ ⊢	ĕ	Φ -	Φ ⊢	Φ -	Φ ⊢	ወ ⊢	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		☐ Ectopic pregnanc☐ Other (specify)	у		23d. Date o	f delivery Day Year
ned oe d	2	Part II. Other significant conditions contributing to death but not resulting	in the	underlying cause gi	ven in Part I.	23e. Did	tobacco use contribute to the cause of death Yes 2∭No 3 □ Probably 4 □ Unkn							
page 2 shor	Completed					24a. Was auto perfe 1 Yes	psy prio ormed? dea	re autopsy findings avail ir to completion of cause th? Yes 2 \(\) No						
this certificated director,	ă ○		ıtpatie	nt 3 DOA Oth	er: 4 🗌 Nursing H		idence 6 Other (Specify)						
within 24 hours after death. To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2	Certification:	1 X Natural 2 Accident 3 Suicide 4 Homicide 1 Y Natural 2 Accident 3 Suicide 4 Homicide 2 Re. Place of injury - At home, fabuilding, etc. (Specify)	Injury arm, st		k? Yes 2 □ No	28f. Location City or To	(Street and Number wn, State)	or Rural Route Number,						
the Funeral Campletely filled	edical Ce	29a. Certifier (check only one) 1 Certifying Physician: To the best of my knowledgrees of examination are and manner stated.	e, deat	th occurred at the tinvestigation, in my	me, date and plac opinion, death occ	e, and due to the curred at the time	e cause(s) and mann e, date and place, an	er as stated. d due to the cause(s)						
To the comple	Mec	29b. Signature and title of certifier Cliftony Lattalone, MD		29c. Licens	e number	sø	29d. Date signed (A	Month, Day, Year)						
3		30. Name and address of person who completed cause of death (Item 23a) Anthony Frattalone			600	North W	olfe St, Balti	imore, MD, 212						
State Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Sol	ale										

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend Item 25 per me,g916,06/10/2011dhb Certificate of Death Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 250 AM Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b City Town or Lecation of Death 4c. County of Death Sex 7. Age (In yrs. last birthday) 8. Date of Birth If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕊 F Months Days Min. (Month, Day, Hours 63 Director Usual Residence of Decedent items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10h. County injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Nes 2 No 1. to more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2/2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 2 Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No. Specify If Yes, Give Year or Dates 3 **②** Widowed 4 □ Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 tammeli las 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 $\cap C$ TIMORE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Termation 3 Removal from State 4 Donation 5 Other (Specify) TIMORO 21. Signal 22. Name and Address of Facility any a Hue, 10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ untraceso disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any local ground cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Dun to for as a consequence on EXAMINE burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria CERTIFICATIO Physician/Medical Division of Vital Records. P.O. Box 58760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Liperandon
Pregnant at time of death ate has been signed by the atte page 2 should be detached for in the past 12 months?

1 Yes 2 No Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available 24a. Was an autonsy prior to completion of cause of death? s after death.

Director: After this certificate Yes funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accid-5 \square Pending injury work? 2 No the Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Gertifying Nurse Prentioner: To the best of my knowle d at the time; date and place, and due to the 29b. Signature and tale of certifier 29d. Date sighed (Month), Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

KIR

31. Date filed (Month, Day, Year,

Varka

16

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state Amend Item 25 per me,g916,06/21/2011dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vea Physician/ 7:45A 2011 White Denise Louise Apri Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Harford Memorial Hospital Havre De Grace Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Min. 1 □ M 2 🛣 F Months Hours 08/01/1958 Maryland 220-10-8060 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director 1 X Yes 2 No Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21901 U.S.A 403 Elk River Manor Drive within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🛣 No Specify. If Yes, Give Specify: Completed 3 Widowed 4 X Divorced White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland 2 t. Page 1 and 2 should be rtment of Health and Mer rtant: If item 27 is marke injury or other traumatic James Joseph Crovo, Jr. Nancy Louise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Christine White / Daughter 726 5th Avenue, Halethorpe, MD 21227 Baltimore, 4 28 11 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State mportant: If 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Speq)(v) 05/03/2011 | Hanover, Maryland Anatomy Gifts Registry permit. 21. Signature of Funeral Service Li 22. Name and Address of Facility Anatomy Gifts Registry any 7522 Connelley Dr., Ste. P, Hanover, 21076 MD 23a. Part 1. Enter the decase or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ANOXIC Immediate Cause (Final BRAIN Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or linjury that initiated expenses Examiner Due to (or as a consequence of) attending physician and I for use as the burial-transit CERTIFICATION APPROVED BY MEDICA that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a \ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy perform Yes 2 No 1 Yes 2 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Division of Vital examiner? 1 X Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of completed filled in by the funeral 28c. Injury at 28d. Describe how injury occurred injury work?
1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 4-28-11 D0069118 Type, Print) Name and address of person who completed cause of death (Item 23a) UTHAWALA ShALID 31. Date filed (Month, Day, Year, State parke Registrar

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		State Registrar 1. Decedent's Name	- (Final 8 4) dall	- / ant)	-		С	ertificate	of L	Death		To p	Reg. No	- U	1 1	10101	
Physicia		Mami	P. F	. War	d							2. Date of De Month		15	Year 20	3. Time of Death 305 AM	
Medic Examin				n, give street and nur				4b. City,		Location		L /	4c.	. County	of Deat	h	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.					1 🗌 Yes	2 X No	Specify	<i>'</i> :				Bla		
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vithi To th	-	29b. Signature and	-	5.4	0				Da	number				1	1-	h, Day, Year)	
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		THOMAS	SM	IILLEN	2000	o u	1BA	-TIMO	rt.	ST	BI	ALTIM	OPE		MD	•	
Sta Registra		31. Date filed (Mont	h, Day, Year)	1 2011 32.	egistra	r's Signat	d. d	barke	9			ALTIM					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 9916 6-21-11 yet. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JUMF 17:40AM Bernard Lee Williams 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE CITY SINAI BALTIMORE MOSPITAL OF N/A 6. Sex 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1932 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1X M 2 D F 037/29/193 VIrginia 79 218-28-2554 **Director** Usual Residence of Decedent show 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No Baltimore N/A MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 2809 Chelsea Terrace 21216 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces?

X Yes 2 \sum No Black, White, etc. 1 Never Married 2 Married ፩ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) A.S. Tours Bus Driver 12th Grade Commercial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alice Smith Oscar Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2809 Chelsea Terrace, Baltimore, MD 21216 Tara Williams(daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 06/23/11 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest permit. of Funeral Service Licensee 21. Synatur ²Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or beart failure. List only one cause on each line. Approximate Interval Between In mediate Cause (Final dl ease or condition resulting in death) Onset and Death Physician/ DIFFUSE CEREBRAL EDEMA FROM ANORIC BRAIN INJURY Medical Due to (or as a consequence of): 2-4 week Examiner FIBRILLATION ATRIAL Samunifelly list or relitions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): HYPERTENSION burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical MYPERLIPIDEMIA IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day Yes detached 1 ☐ Yes 2 L 9 ☐ Unknown Unknown Division of Vital Records, P.O. been signed by the should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available 24a. Was an page 2 prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 To the Hospital or Attending Physician: The After this certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1
Yes 2 No death. Accident Investigation within 24 hours after deat To the Funeral Director: pleted filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 MD JUNE 11,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SWATI PANDEY MD SINAL HOSPITAL OF BALTIMORE 31. Date filed (Month) Day Year) State Registrar

WILLIAMS,

KNOWY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\overset{\text{Day}}{2011}$ Physician/ Month June 20 3:25 A. John Benton Webb, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Shady Grove Adventist Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex '. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days 1 🔀 M 2 🗆 F Hours Min. Months 1924 Washington, D.C **Director** 578-12-6009 86 Aug. Usual Residence of Decedent show 10a. State 10b County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene.

Department of Health and Mertal Hygiene. In Important: If items 23 is an 28a f sho important: If item 27 is marked of the than "natural", or items 23a or 28a f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 X Yes 2 ☐ No Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20877 333 Russell Avenue, #612 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? Black White etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: White 3 X Widowed 4 ☐ Divorced Completed WWII Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Printing Photoengraver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Olive Cox John Benton Webb Webb, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2224 Wintergarden Way, Olney, Maryland 20832 Virginia Webb Styer / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc. June 21, 2011 Bethesda, Maryland 21. Signature of Funeral Ser Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, MD 20850-2805 M00896 23a. Part 1. Enter the disease, or complications that caused shock, or leart failure. List only one cause on each line. Immediate Cause Final bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate Interval Between Onset and Death Bleedin Ph_sician/ Intracrania disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury anding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical (o Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy
 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death been signed by the should be detached 1 ☐ Yes ∠ □ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? Yes 2 No After this certificate has To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 25. Was case referred to medical examiner?

1 4 Yes 2 \(\sum \) No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred ☐ Natural injury 5 Pending 0545 AM 2 X No floor tound Investigation 06/14/2011 On 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State)
13 Russell Ave +612 hivina Assisted 333 MD 20877 Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) June 20, 2011 6062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850 mo 10110 Molecular yyad

DHMH 17 Rev 7/2009

State Registrar

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6/20/2011

32. Registra s Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month WARFIELD PHYLLIS 20 2011 JUNE 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center **Baltimore** 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 6. Sex Social Security Number West Virginia 1 □ M 2 🛛 I 74 November 216-32-9115 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☑ No Dundalk Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code USA 21222 802 Mildred Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Accounting Secretary 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lorraine M. Michaels Orville Barker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 802 Mildred Avenue, Dundalk, Maryland James R. Warfield Jr. Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) June 23, 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland Meadowridge 2011 21. Signature of Funeral Service Licensee Connelly Funeral Home of Dundalk, P.A. 21222 7110 Sollers Point Road, Dundalk, Maryland 23a. Part 1. Enter the disease or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 24 h SEPTIC disease or condition resulting in death) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d Date of delivery 2 Fetal death 1 Live birth 3 🗌 Ectopic pregnancy Month Day Year in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 ☐ Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

other than "natural", ent, the Medical Exa

ealth and Mental Hygir n 27 Is marked other er traumatic event, th

permit, Pages 1 and Department of Health Important: If Item 27 any Injury or other troonee.

with the

Pages 1 and 2 should be filed within 72 hours after death oner to Health and Mental Hygiene.

21215-0036

Baltimore, Maryland

Director

Funeral

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Completed

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Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit this ours after death.

leral Director: After the filled in by the funers.

Division of Vital Records, P.O. Box 68760.

Sequentially list conditions, if any, issuing Cause. Enter Underlying Cause (Disease or injury that initiated events southing in death). Examine resulting in death) Last Physician/Medical 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 KInpatient ၉ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: Injury 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) RES-000 June 20, 2011

4940 Eastern Avenue, Baltimore, MD, 21224

State Registrar

within 24 hours a

				L, ZJ, Z	Department of 27,28a-f per Certificate o	f Death	Reg.	No.	3. Time of Death
nysicia	ın	1. Decedent's Name (First, Middle,					Month	Day Year	12:05 A M
Medic	E	Mary Elsie Aufre			4b. City, Town	, or Location of Death	riay 17, 2	4c. County of Dea	
amino	er	Envoy of Denton	,		Denton		C	Caroline	
eral		<u> </u>		ge (In yrs. la	Months Day	s Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Co	thplace (State or Foreign ountry)
tor		579-14-6309 Usual Residence of Decedent	1 M 2 X F 93	3	Yrs.		July 21,	1917 Mary	yland
E	ŀ	10a. State 10b. County		10c. City,	Town or Location				10d. Inside City Limits
and in the second secon	ctor	Maryland Carolin	e	Dent	on				1√Yes 2□No
	Dire	10e. Street and Number			10f. Zip Code	е		Citizen of What Co	ountry?
ĺ	rall	420 Colonial Dr		F i- 11.0	21629	6 Ution and Origin 2 (Spe		JSA 14. Race - Ame	erican Indian
	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? d 1 □ Yes 2 ▼ If Yes, Give Year or Dates:	?	if Yes, specify C	of Hispanic Origin? (Specuban, Mexican, Puerto No Specify:	Rican, etc.)	Black, Whi	te, etc.
	Completed	15. Decedent's (Specify only highest	Education grade completed)	1	16a. Decedent's Usual Oc (Give kind of work do	ne during most of work	ing 16t	b. Kind of Business	/Industry
	ď	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT use ret Bookkeeper	ared)	Re	tail Indu	ıstrv
	ပ္ပိ	12 17. Father's Name (<i>First, Middle, La</i>		1	bookkeepei	18. Mother's Name	(First, Middle, Mai		1001
	To Be	Alvin Edwards	,			Mary Elsi	e Coursey	•	
	-	19a. Informant's Name/Relationshi			19b. Mailing Address (Stra 4-74 48th Av	eet and Number or Run enue, Apt.	al Route Number, C 26J, Long New	ity or Town, State, g Island York 111	Zip Code) City, .09
		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 4 □ Donation 5 □ Other (Special Control	3 □Removal from State	ce	ace of Disposition (Name of metery, crematory or other ensboro Cemet	place)		c. Location - City o	r Town, State , Maryland
يَو		21. Signature Fup al Service L		1020	22. Name and Ad	dress of Facility			
OUC	9 3	Itan	fra		PO Box 16	and Helfenb 00, Greensb	ein Funer oro, Mary	land 21	639 ^A .,
		23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cause nly one cause on each I		Do not enter the mode of	dying, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
ın	W N	Immediate Cause (Final disease or condition	- cdv	rra	cture Right	нтр			23 days
cal ner		resulting in death) Sequentially list conditions,	Due to (or as Advance		ence of): entia & Bala	nce Disorde	er		Chronic
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C	ovascu	lar Disease				Chronic
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	dical	`	d			OF OTHER ATION A	PPROVED BY MEDICA	T Com.	
	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth	d. 23c. If yes, outcome pf pregnancy CERTIFICATION APPROVED BY MEDICAL EX 23c. If yes, outcome pf pregnancy Live birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) 9 Unknown					
	Ph)	Part II. Other significant condition	ns contributing to death I	but not resu	Iting in the underlying cause	given in Part I.	23e. Did toba	cco use contribute	to the cause of death?
	d by	Sacral Decubitu					1 ☐ Yes	2 № 3 □	Probably 4 Unknow
	lete						24a. Was an	24b. Were	autopsy findings available completion of cause of
	ртр						autopsy performe 1 Yes 2	ed? 🖊 death?	o completion of cause of es 2 No
	Be C	25. Was case referred to medical				26. Place of Dea	th (Check only one)		
	To B	examiner?	Hospital: 1 ☐ Inpat	tient 2 🔲	ER/Outpatient 3 □ DOA	Other: 4 Nursing H	ome 5 Residen		pecify)
	:uo	27. Mann of Death 5 ☐ Pending	28a. Date of Inj (Month, D	jury Jay Year)		Injury at Work?	Fell whil		ting
	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	April 2	24,2011 njury - At ho etc. <i>(Sp</i> ec <i>if</i> y	5:30 p ^M me, farm, street, factory, off	1 ☐ Yes 2 🛣 No fice	28f. Location (Stre	et and Number or	Rural Route Number, Colonial Dr.
		29a. Certifier 1 ☐ CertifyIng	Nursing Physician: To the bes	at of my know	vledge, death occurred at the	ne time, date and place	, and due to the cau	use(s) and manner	as stated.
	Medical	(Check only 2 Medical E	xaminer: On the basis and manner s	of examinat	ion and/or investigation, in	my opinion, death occu	rred at the time, dat	te and place, and d	ue to the cause(s)
	Me	29b. Signature and title of certifier				cense number		d. Date signed (Mo	nth, Day, Year)
					21413) D.	005325	5	5/17/	1106
		30. Name and address of person w	who completed cause of	death (Item	23a) (Type, Print)	R2 8,	reston 1	e an	1622
Sta istr		31. Date filed (Month, Day, Year)	32. Regis	strar's Signa					
v 1/2	001								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:30p M J_{une}^{Month} 4, 2011Marian Elizabeth AXLINE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Broadmore Senior Living Washington Hagerstown Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dec. 16, Hours Year) 1920 Maryland 329-20-3165 90 Yrs. **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Smithsburg Washington 1 ☐ Yes 2 🏝 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a o other traumatic event, the Medical Examiner must be Funeral 21312 Twin Springs Drive U.S.A. 21783 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha registered nurse hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Carlton Marker Bettie Blanche Beachley Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Susan McAllister - daughter 22120 Pikeside Drive, Smithsburg, Maryland 21783 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery crematory or other place).
Cedar Lawn Memorial Burial 2 Cremation 3 Removal from State June 82011 Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen Minnich Funeral Home 22. Name and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause BURNU nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes completed filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an 24 hours after death. Funeral Director: After this certificate has been sent the section of the autopsy performed? Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 2 □ No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature. otitle of certifier D40622 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19236 MERSOW VIEW DR AARBRITOWN MODIAY

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Anné Arundel Annapolis Anne Arundel Medical Center . Social Security Number 8. Date of Birth If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday, (Month, Day, 1 XM 2 □ F Days Months . 1913 213-07-9851 97 Marvland Director Dec. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Millersville MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21108 8001 Horicon Point Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 X No White If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel 8 Nail Machine Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen Kalinowski Walter Andrzejewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Toyra, State, Zip Code) 8001 Horicon Point Drive Millersville, MD 21108 Dorothy Andrzejewski/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Sacred Heart of Jesus
Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 06, 2011 Dundalk, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Theumoni Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and I-transit that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Box 68760 attending properties for use as as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 2 🗌 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown the hed Division of Vital Records, P.O. s been signed by I should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has i autopsy certificate 1 Yes 2 No Yes 2 NON director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ပ္ 2 X No 1 → mpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1 Al Natural iniury ☐ Accident ☐ Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 06 03/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (M

Michel

Annapolis

21401

,MO

Zoul Medical Parkway

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Monthe 2010 2011 Physician/ Edward Anthony ASHKETTLE, SR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Meritus Medical Center Hagerstown 8. Date of Birth (Month, Day, Feb. 5, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Country) Mary Land Hours 220-42-5157 64 Yrs. Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f shor 10a. State 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1

Yes 2 □ No Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 U.S.A. Funeral 1404 Salem Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married 1 X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) painter glass company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Eleanor Virginia Bowman James Edward Ashkettle, Sr. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1404 Salem Avenue, Hagerstown, Maryland Ruth Ashkettle - wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State June Hagerstown, Maryland 2**ó**11 Hagerstown Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licens Minnich Funeral Home Ula. 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a, Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lin Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) consequence **Examiner** Sequentially list conditions Examiner it any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 2 🗌 No 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hin 24 hours after death.

the Funeral Director. After this certificate has autopsy, perform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, Be 1 🗌 Yes Inpatient 2 - ER/Outpatient 3 - DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death . Date of injury (Month, Day, Year) 28a 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one within To the 29d. Date signed Month, Day, Year) 29b. Signature 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KALIM Ahmed 12821 Oak Hill

State Registrar KALIM Ahmed

32. Pagistrar's Signature

Hill Ave, HASerstown, mo

21747

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Leonard Anderson, Jr. John 2011 2:34 P. M May 30. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Heartland Health Care Center Hyattsville 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 1929 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) X M 2 1 578-30-8587 81 **Director** 16 Washington, D.C. December Usual Residence of Decedent Show 10a. State with the Maryland 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Prince Georges Hyattsville 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe Funeral 23a 6905 - 17th Avenue 20783 United States must within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces? US Army
1 X Yes 2 March
1946 Yes 2 X No Specify: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married by Maryland 21215-0036 **Black** Completed 3 Widowed 4 Divorced Specify: Year or Dates April 1947 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Firestone Automotive Elementary/Seconday (0-12) College (1-4 or 5+) 10th grade Auto Mechanic & Tires Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe John Leonard Mary Anderson, Sr. Sadie James other traumatic Page 1 and 2 should and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is Marie Green Anderson (Wife) 6905 - 17th Avenue; Hyattsville, Maryland 20783 Department of Heal Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June ^{D#}, 2011 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Quantico, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Quantico National Cemetery 21. Senature of Juneral Service Lig 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner 7.GNS18N Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events. Examine attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes__2 X No 1 🗌 Yes 2 🗌 No _ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Certificate: To 2 X No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at s after death. 28b. Time of 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge 29b. Signature at d title of certifie 29c. License number 29d. Date signed (Month, Day, Year) , 2011 June 3 D46529

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day

JUN 0 7 2011

Victor Onyejiaka, M.D.;7325-A Hanover Parkway; GreenBelt, Maryland 20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State . Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jog[1:21 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Deat 4c. County of Death BALTIMORE MEDICAL MARYLAND 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Nigeria 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F Hours 256-99-3744 49 Director N4/N4/1962 Usual Residence of Decedent 28a-f show at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director notified MD Prince George's Mt. Rainier 1 X Yes 2 □ No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 3312 Buchanan St. 20712 Apt. 301 AZU 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 1 Yes 2 No ò 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black "natural" 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Government the Correction Officer traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ David A. Adesuvi Felicia Sule Department of Health and Important: If item 27 is m any injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3312 Buchanan St. apt301, Mt. Rainier, MD 20712 Florence Adesuyi / wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Heritage Memorial Cem: Ob/O4/2011 Waldorf, MD 4 Donation 5 Other (Specify) 21. Sign ture if Funeral Service License 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 23a. kart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical P.O. Box 68760 as IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Pregnant at time of death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Por Month Year the 9 Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate Yes 2 🔽 **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 🗹 No မြ 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, this 27. Man of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending of Puners after death.

Funeral Director: After detections of the functions of the function 1 🗌 Yes Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) M.0.30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENJAMIN SHANPER M.D. State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nadine Bigbee June 6, 2011 8:05 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11408 Tippett Road 20735 United States Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Age (In yrs, last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours 1 - M 2 X 95 Months (Month, Day, Year) 448 22 7975 **Director** Missouri 1915 June 16. Usual Residence of Decedent or 28a-f show Director 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Prince George's Clinton 1 ☐ Yes 2 🟋 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11408 Tippett Road 20735 <u>United States</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) $\overset{\text{Elementary/Seconday }(0\text{-}12)}{12}$ College (1-4 or 5+) Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pearl Perrigo Ruby Metcalf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Bigbee (Daughter) 11408 Tippett Road, Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 6-23-2011 4 Donation 5 Other (Specify) Arlington National Cemetery Arlington Virginia 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of uneral Service Lie Ferry Road Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Seque it ally list our cities if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After the death of the state of the funeral Director After the death. sate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2/No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy perform death? 1 Yes Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: ျ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d, Date signed (Month, Day, Year) s of person who completed cause of death (Item 23a) (Type, Print) 7032

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death June 2, Physician/ 201^y1 James W. Barbera 5:55AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Center Towson 8. Date of Birth (Month, Day, Yea Dec _ 14, 9. Birthplace (State or Foreign Country)
Maryland Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 1 🛛 M 2 🗆 Days Hours Min. Director 218-56-2196 58 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be nortified a 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Cockeysville 10e. Street and Numbe 10g. Citizen of What Country? Funeral 10737 Lakespring Way 21030 USA Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black White etc. Completed by I 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify If Yes Give 3 Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Rusiness Industry Elementary/Seconday (0-12) College (1-4 or 5+) 2 Courier Delivery Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Joseph S. Barbera Kathleen Rigley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other trong once. Kathleen Barbera / Mother 10737 Lakespring Way, Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Keurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Dulanev Valley M.G. 6/8/2011 Timonium, MD 22. Name and Address of Facility Beall Funeral Home Signature of Funeral Service Licenses 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Mutactione adenocerationa unknown prima Physician/ disease or condition months Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine draw, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician al s the burial-t Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as attending p IF FEMALE nse s 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Pregnant at time of death 5 Other (specify) Dav Year the 9 Unknown Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed? Yes 2 WN 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death I Director: After to in by the funeral 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No □ Accident Investigation 3 Suicide 4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined after 24 hours Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the To the To the To the 29b. Signatura 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1-tANIES 6701 31. Date filed (Month. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ enne tt 11032 104 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot aston memoria Hospital If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 1 **W** M 2 □ F 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Country) Marylano 214-32-62 42 Months Days Hours Min. Director Usual Residence of Decedent ortant; If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Nes 2 No on 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral anding 45 Neck 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates 3 Widowed 4 □ Divorced Completed Black 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) -edera Worker intenance Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other them. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Bennett rank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) anding Neck Rd. Easton, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State 6 4 ☐ Donation 5 ☐ Other (Specify) ra 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Henry Funeral M 23a. Part. Enter the disease, or complications that caused the bath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Seplic Shock disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Due to (ours a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Bowc attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day 2 No ed by the a detached f 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? habdomyolysis 24a Was an has le 2 s autopsy r this certificate has eral director, page 2 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other 1 🗌 Yes ည No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number MD D0069457 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kalakurthy Samantha, Easton memorial hospital, Easton MD Kalakurthy 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** OOAM John lake 2011 Mai /Medical 4d. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Mallard Care Center Bay Dorchester If Unde 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number Funeral YDM 2□F Min Months Days Hours 220-26-184 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location death with the Marylar ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Ves 2 No Director Talbot Trappe 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 4062 Diamond U5A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? 1 ☑Yes 2 ☐ No 195/ Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☑Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ ottie V:0/a EMORY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is Bruce Upper May boro, Mary land 20772
Date | 20c. Location - City or Town, State 711-Main Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 3/11 4 ☐ Donation 5 ☐ Other (Specify) 61 Hurlock, Veterans Cemetery: 6/3/11

22. Name and Address of Facility
Henry Funeral Home, P.A. 21. Signature of Funeral Service Licensee washington St. Cambridge, Maryland 21613 23a. Part . Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancel iung HEN /Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant ned by the atter detached for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has page 2 autopsy performed? Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA s after death. 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

State Registrar 31. Date filed (Month, Day, Year)

iciaJohn

100 Branble
12. Jegistrar's Signature
12. Jegistrar's A. Jane

1. Decedent's Name (First, Middle, Last)

Eunice W. Brown

Physician

/Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Funeral Director: completely filled in by the within 24 hours a

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 6 9 ☐ Unknown	al death 3 Ectopic			23d. Date of delivery Month Da			
Part II. Other significant conditions A17 heims	_	/	g cause given in Part I.	23e. Did tobacco	o use contribute to the o	. /		
gastro-inte	stimal k	leed		24a. Was an autopsy performed?	death?	letion of cause of		
25. Was case referred to medical examiner?				ath (Check only one)				
1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing H	lome 5 Residence	6 ☐ Other (Specify)			
27. Manney of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day, Year) on	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? M 1 Yes 2 No						
3 ☐ Suicide 6 ☐ Could not determine		ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, Sta	Street and Number or Rural Route Number, wn, State)			
29a. Certifier 1 Certifying I 2 Medical Ex.	Physician: To the best of my known aminer: On the basis of examination and manner stated.	owledge, death occurration and/or investigati	ed at the time, date and place on, in my opinion, death occu	e, and due to the cause urred at the time, date a	e(s) and manner as stat and place, and due to th	ed. ne cause(s)		
29b. Signature and title of certifier	M	-MD 2	29c. License number 05072		Date signed (Month, Da $-31-20$			
30. Name and address of person on the second of the second	eding or &	501 Vete	rans Hwy	Millers	rlle Mi	321108		
31. Date filed (Month. Day Year)	82. Registrar's Signa	ature /	1	_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

30 Day

2011

4:10 PM

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 No

Mississippi

Black

21401

Approximate Onset and Death

month

2. Date of Death

May

State Registrar

Be

Medical Certification: To

JUN 0 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Day 2 Physician/ Month Shirley Mae Babington 14 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Month, Day, 1 □ M 2 🙀 F Months Days Hours Mir Director 220-30-9916 78 Yrs Maryland Usual Residence of Deceder "natural", or items 23a or 28a-f show edical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Washington Maryland Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12814 Bradbury Avenue 21783 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ith and Mental Hygien 27 is marked other the traumatic event, the 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Alvin Lewis Miller Bessie Estella Staubs t. Page 1 and 2 should by treent of Health and Mertant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other the once. Harold E. Babington/husband 12814 Bradbury Avenue, Smithsburg, Maryland 21783 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 😾 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory 06/07/11 Frederick, Maryland 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. of Funeral Service Licensee 606 Old National Pike, Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e. ch line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) DISTASI Examiner Sequentially list conditions Examine If any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death be detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After 1 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation the 24 hours after deat Funeral Director: Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [To the Within 2 To the F only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) M.D

State Registrar 30. Name and add

31. Date filed (Mont

20181300

person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

GM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Paul Donald Black	1- For State Registrar		partment of ertificate of		d Mental Hy	Reg	2011 g. No.	974		
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Las Pau		lack			2. Date of Death Month May 25, 20	Day Year	3. Time of Death 1148 hrs		
	4a. Facility Name (if not institution, given Shady Grove Adventist He	e street and number)		tb. City, Town, or I Rockville	Location of Death	ay 20, 20	4c. County of Death Montgomery	· · · · · · · · · · · · · · · · · · ·		
Funeral Director	5. Social Security Number 6. Social Security Number 1		s. last birthday) 68 Yrs.	If Under 1 Year Months Days		7	irth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Mary Land			
ow any	Usual Residence of Decedent 10a. State 10b. County		ity, Town or Locati	_				10d. Inside City Limits 1 Yes 2 No		
e Maryland or 28a-f show any fied at once. Director	Maryland Montgon			10f. Zip Code	nascus	10	g. Citizen of What Coun	try?		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28s-f sho or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	25413 Clearwater 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in	If Y	s Decedent of Hisp es, specify Cuban,			14. Race - Americ White, etc.			
hours after 'natural'', o Examiner :	3 Widowed 4 Divorced 15. Decedent's Education (Specify o Elementary/Secondary (0-12)	If Yes, Give Year or Dates: nly highest grade completed College (1-4 or 5+)		Yes 2 No t's Usual Occupations of working life.			Specify: Whit			
ID 21215-0036 should be filed within 72 hours aft and Mental Hygiene. 77 is marked other than "natural" natic event, the Medical Examine To Be Completed by	17. Father's Name (First, Middle, Last	12		Chef	B.Mother's Name	(First, Middle, M	Food Indu	istry		
21215 ould be file d Mental H is marked of tic event, til	Ralph D. Black	Type Print \	19h Mailine		Kathleer			Zin Code)		
T it is	Nancy Kay Black, Wife 25413 Clearwater Drive, Damascus, MD 20									
imore, MD 2 Pages 1 and 2 shou ment of Health and h tant: If item 27 is n or other traumatic	20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	b. Place of Dispos crematory or oth Metro	politan			20c. Location - City or	•		
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other fraum	21. Signature of Funeral Service Licer	Thulan XX C	Crematori 22.N Mo Da	ame and Address lesworth mascus,	of Facility 1-Willian	ns. P.A.	Alexandria , Funeral F			
Physician Medical xaminer	The state of the s			ne mode of dying,	such as cardiac or	respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death		
	or condition resulting in death) Sequentially list conditions, b.	Due to (or as a consequence								
0, be executed sician and burial - transit edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that imitated events resulting in death) Last	Due to (or as a consequence								
50, te be executed sysician and burial - transit	d. UNPENDED	AMENDED								
18760, rtificate be con ing physicia as the buria an/Medi	JE SEMALE.	23c. If yes, outcome of pr		tal death 3	Ectopic pregnar	псу	23d. Date of delivery Month D	ay Year		
D.O. Box 6876 that the death certificate and by the attending phydetached for use as the by Physician/M	1 Yes 2 No 9 Unknown	9 OIINIOWII	3 011	ner (Specify)						
s, P.O. iires that the signed by d be detack		contributing to death but no scular Disease, Multip		nderlying cause gi	iven in Part I.	1 Yes	pacco use contribute to t 2 ✓ No 3 ☐ Prob	ably 4 Unknown		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi edical Certification: To Be Completed by Physician/Medical Exhibitation: To Be Completed by Physician/Medical Exhibitation:						24a. Was a autops perform 1 Yes 2	y prior to coned? death?	opsy findings available ompletion of cause of s 2 No		
Vital Rec ysician: The last certificate director, page	25. Was case referred to medical	Hospital: 1 Inpatient 2	✓ ER/Outpatient		of Death (Check of Other Nursing		Residence 6 Other			
on of Viending Physicath. or: After this the funeral dir	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) May 25, 2011	28b. Time of In 1100 hrs	· · · _ · ·			ow injury occurred xed object collisio	n		
Division or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune fedical Certification:	2 Accident Investigat 3 Suicide 6 Could not determine	be 2Be. Place of Injury - A		et, factory, office bu		or Town, Sta	treet and Number or Ru ate) eld Road, Gaithersbu			
To the Host within 24 ho To the Fun completely f		ian: To the best of my knowledge. To the basis of examination and manner stated.								
	29b. Signature and title of certifier			29c. License O.C.M			29d. Date signed (Mor. May 26, 2011	nth, Day, Year)		
30	30. Name and address of person who Donna M. Vincenti, MD	completed cause of death (It		W. Baltimore	Street, Baltim	nore, MD 212	223	-		
State Registra	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	barker						
	205 Gra H - "% 7	1-34 LT L ACCOUNTS	THE PARTY OF THE PARTY							

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State

Registrar

68760

Box

P.O.

Records,

Division of Vital

ande

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

ion who completed cause of death (Item 23a) (Type, Print)

MC

CPT

D.

IIIN O

31. Date filed (Month, Day, Year)

CARUSO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 1, William Frederick Blumenberg 2011 2:38 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Frederick Kline Hospice House Mount Airy Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Jan. 1929, Year 929 Days Hours 1 K M 2 D F 82 New York Director 108-22-1178 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 217 Bishops Glen Drive 21702 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married 1 XX Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 rt Yes, Give Year or Dates. 1950-53 1 ☐ Yes 2XX No Specify: White 3 Widowed 4 Divorced Specify 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Naval Research Structura1 Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Johanna Bauer William Karl Blumenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marianne Blumenberg Wife 217 Bishops Glen Dr., Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ^{Date}, 2011 no. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Gardens 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June Frederick, Maryland . Sign three of Ferend S wice Licensee Skkot Cody P.A. Frederick, MD 21701 Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Approximate Interval Betweer Immediate Cause (Final disease o condition resulting in death) Onset and Death Myocardial Ischemia Physician/ hours Medical Due to (or as a consequence of): Examiner weeks Metastatic Melanoma Sequentiary liet conditione, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): iding physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ hed by the attent detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? 1 🗌 Yes 2 No Yes 2 K No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No မ 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury work? 1 Yes 2 🔲 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 1 XX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b Signature of title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 3, 2011 6.1 WW D 44164 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

5+IVA

A.Z.

31. Date filed (Month, Day, Year)

Hegazi, M.D.

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46

32. Regis ar's Signature

B Thomas Johnson Dr., Frederick, MD 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		for State of Maryland / Depa	rtment of Health a tificate of Death	and Mental Hy	201	19750
-		Registrar 1. Decedent's Name (First, Middle, Last)	incate of Death	2. Date of De	Reg. No.	3. Time of Death
Physicia Medic		Eunice Marie Bailey		Month June	3, 2011 Year	1:00 PM
Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of		4c. County of Deatl	h
A		Sacred Heart Home	Hyattsvi	11e	Prince G	eorge's
Funeral Director		5. Social Security Number 578-44-0457 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of Bi Min. (Month, D. Februar)	orth 9. Birth ay, Year) 7 2, 1924 Was	hplace (State or Foreign untry) hington, DC
d d	ايا	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Loc	ation			10d. Inside City Limits
nylan I-f sh ied a	cto	Maryland Prince George's University				1 X Yes 2 No
or 285 notif	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	
vith th		4108 Tennyson Road	20782		USA	and,
ems ems	Funeral	11 Marital Status 12, Was Decedent Ever in U.S. 13, W	/as Decedent of Hispanic Orig	gin? (Specify Yes or No		rican Indian,
or if	by F	1 X Never Married 2 Married 1 Yes 2 No	Yes, specify Cuban, Mexican	, Puerto Rican, etc.)	Black, White	
ours after	Completed	3 Widowed 4 Divorced Year or Dates.	Yes 2 X No Specify:		Specify: W	hite
72 ho	ple	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give k	ent's Usual Occupation ind of work done during most) NOT use retired)	of working	16b. Kind of Business U.S. Depart	
thin the M	S		Clerk		Immigration	
Hygi other ent, t	Be (17. Father's Name (First, Middle, Last)		er's Name (First, Middle	e, Maiden Surname)	
ylding ld be filed Mental Hy arked ott	ပ	Joseph Clarence Bailey	Eliz	abeth Este	lle Moran	
and Nama			g Address (Street and Numbe			
and 2 sl Health a Health a Health a Health a		John T. Fischer / Nephew 12425	Keeneland Pl	ace, Gaith	ersburg, MD	20878
e d a le		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposicemetery, crem	atory or other place)	Date	20c. Location - City or	
t. Pag trent tant:		4 Donation 5 Other (Specify) Cedar Hill		6/10/2011	Suitland,	
DEJILITIOFE, IMERYIAING Z IZ 13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		Ba A a	Name and Address of Facilit			imore Avenue
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter	asch's Funeral			Approximate
DISCOURT OF THE PARTY OF THE PA		shock, or heart failure. List only one cause on each line.	Ø			Interval Between Onset and Death
Phy_ician Medical	G - 1	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of the consequence of the consequence)	Artery D)isease		UNKHOWY
Examiner		but to for as a consequence of.				
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):				
cuted nd ransit	cam	Cause (Disease or iinjury that initiated events c.				
ate be executed physician and the burial-transit	dical Examiner	resulting in death) Last Due to (or as a consequence of):				
ate by	adic	d				
sertific ding p	Ň/u	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of del	livery
death c	icial	in the past 12 months? 1 Ves 2 No. 1 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month	Day Year
the di	Physician/Me	g □ Unknown 9 □ Unknown				
v requires that the death certifics to been signed by the attending p should be detached for use as t		Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I		tobacco use contribute to	
daulire equire en si	ted			1	Yes 2 No 3 P	robably 4 Mar Unknown
The law requires ate has been signage 2 should be	Completed by			24a. Was	opsv prior to o	topsy findings available completion of cause of
The cate h				1 Yes		2 🗆 No
VILCII ysician: is certific director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Input lent 2 FR (Outpotion)	Other	h (Check only one)		
Phys Phys	은 ::	1 Yes 2 No 1 Inpatient 2 ER/Outpatien 27. Man fer of Death 28a. Date of Injury 28b. Time of	t 3 ☐ DOA 4 M Nu 28c. Injury at		sidence 6 Other (Spec how injury occurred	ify)
or Attending P or Attending P iffer death. Director: Affer the	cate	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	work? M 1 ☐ Yes 2 ☐	1	mon injury cocamo	
Atter er deg ector by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office		(Street and Number or Rui	ral Route Number,
Ital or saft all Directions and Dire				4		
Hosp 24 hou Fune ted fil	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death o 2 Medical Examiner: On the basis of examination and/or investi	igation, in my opinion, death oc	curred at the time, date	and place, and due to the	cause(s) and manner stated.
DIVISION OF VITAL RECORDS, P.O. BOX 00/00 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Ž	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, d 29b. Signature and title of certifier	eath occurred at the time, date 29c. License number	and place, and due to t	the cause(s) and manner as 29d. Date signed (Month	
F S F O		Adre Show Mn	25100	-	June 6	
0 1		30. Name and address of person who completed cause of death (Item 23a) (Type, P	rint)			1
V)		Andres Salazar 3621 Ligon R	d, Ellicott Ci	ity, MD	2042	
Sta Registra		31. Date filed (Month, Day, Year) 32. Registry's Signification of 2011	,	1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 05/247/2011 1:00 P Nancy Ball Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Burtonsville Sanctuary at Holy Cross Burtonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Age (In yrs. last birthday **Funeral** Hours 1 M 2 X I d\$%20%1°958 DC Director 53 578-78-1730 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at Director District Heights Prince Georges 1 X Yes 2 □ No MD 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral AZU 20747 2014 Oakwood Ln permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11, Marital Status Armed Forces? Black, White, etc þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Ves Give Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Hospital Environmental Service Aide 75 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Brown ဂ္ဂ Abraham Ball, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2014 Oakwood Ln., District Heights, MD 20747 19a. Informant's Name/Relationship (Type, Print) Tanya Ball / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Cother (Specify) 0P\05\5077 Suitland, MD Washington National 21. Signa of Funeral Septice Licanie 22. Name and Address of Facility Strickland Funeral Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENCEPHALOPATHY. Physician/ HNOYIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a number unne of) if any, leading to immedicause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed ttending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ed by the 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 : has performed 2 No 1 Yes certificate 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) funeral director. ၉ 1 Inpatient 2 ER/Outpatient 3 I Nursing Home 5 Residence 6 Other (Specify this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🔲 Yes 2 🗌 No 24 hours after death. Funeral Director; A Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ģ determined filled in Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu elicell me and address of person who completed cause of death (Item 23a) (Type, Print) 2835-State

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend Items 29c d 30 per dr , 918 08/03/2011 dhb.

Amend Items 25,27,28a-f per MFg 217 097629/2011 dhb

Reg. N. 2 0 | | 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June Roscoe Dewitt Corderman 7:00 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fahrney Keedy Home and Village Boonsboro Washington County If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 XM 2 - F May 22, Year 916 214-09-4181 Maryland 95 **Director** Usual Residence of Decedent f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A. 323 Key West Dr. 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 1 No 5If Yes, Give 1945Year or Dates. 1946 Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 XDivorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Railroad Engineer 8 Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Irene LeFever Corderman Luther Corderman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3069 Harmony Church Rd. Darlington, MD 21034 Ann C. Helton-daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Broadfording Church Cemetery 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 6-8-2011 Hagerstown, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Onset and Death Chrysician/ Ineumonia disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 X Yes Other: 2 100 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury Found 1. Day, Year) 05/06/2011 27. Manner of Death 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred **Ha**tural 5 Pending 2 X Accident Unknown M 1 ☐ Yes 2 🗶 No Subject fell Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 323 Key West Drive Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Home Hagerstown MD 2ga Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D50362 June 2, 2011 VE+-1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IW-9 Vincent Cantone, M.D., White Oak Pediatric and Adult Medicine, Hagerstonw, MD 21742 31. Date filed (Month, Day, Year) State JUN 06 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Gertrude The 1 ma Carr 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Laurelwood Care Center Ceci1 E1kton 5. Social Security Number If Under 24 Hrs. 8. Date of Birth If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Days Hours (Month, Day, Year) 02/14/1929 Director 82 222-16-9273 DE Usual Residence of Decedent or 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director E1kton 1 Yes 2 No MD Ceci1 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 177 Kennedy Blvd 21921 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify White Specify Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Education School Administration Be permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant: If item 27 is mornary injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mabel Moore Louis Thompson 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 177 Kennedy Blvd. Elkton, MD 21921 Constance B. Thompson Daigle 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 06/10/2011 1 Burial 2 X Cremation 3 Removal from State R.T.Foard Funeral Home, P.A. Rising Sun, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Pune al Service Licensee 22. Name and Address of Facility R.T.Foard Funeral Home, 259 East Main Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ myocal disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical OPD Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) q Unknown n signed by tt. 1 be de⊷ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 Vo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has ' autopsy Condiae After this certificate 1 Yes 2 No Yes 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) 20 Hospital Other ျ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work?
1 Yes 2 No Accident Director: / Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined a 24 hours a Medical 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d Date signed (Month Day Year) 202 W D

Registrar

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ted cause of death, (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Yea ERNADETTE 0630 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Anne Arundel **Examiner** Annapolis Ginger Cove Health Center . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 4 Days Hours 89 474-07-6944 **Director** 1921 Minnesota Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Anne Arundel Annapolis Maryland 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 U.S.A. 4226 River Crescent Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter A. Casey ဂ္ Margaret B. Doody 19a. Informant's Name/Relationship (Type, Print)

Jody Noland/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 625 Willow Knoll Drive Marietta, Georgia 30067 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Baltimore Crematory 6/6/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) ation 5 __ 22. Name and Address of Facility John M. Taylor Funeral Home Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ALVULAR EART DISEACE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Due to jor as a consequence of cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Yes 2 been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performe certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural 2 Accident injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗜 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29b. Signature and title of certifier 29c. License number d cause of death (Item 23a) (Type, Print)

State Registrar Name and address of perso:

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011 Alice E. Carr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BURNIE BATIMORE WARHINGTON MEDICAL CENTER GLEN ANNA (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Social Security Number (Month, Day, Year) 08/07/1923 1 □ M 2 🛣 F Country Director 219-16-1841 Maryland Usual Residence of Decedent 10a, State 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director 1 ☐ Yes 2 🔽 No MD Anne Arundel Crownsville 10e. Street and Number 10g, Citizen of What Country? 1250 Bill Carr Road Funeral 21032 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 XNC Baltimore, Maryland 21215-0036 1 Yes 2 XNo White Specify: Specify: 3 X Widowed 4 □ Divorced Year or Dates is marked other than "natur aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Board of Education Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Eugene Jarboe Jeanette Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traionce. Donna C. Blankenship daughter 20 Prospect Bay West Grasonville, MD 21638 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran's 06/09/2011 Crownsville,MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility 851 Annapolis Road Gambrills,MD 21054 Hardesty Funeral Home P.A. Jak 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 2º WEEL LUNG Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy perform Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🖪 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation Il Director: A 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after To the Funeral Direct Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) License number

45146 29d Date signed (Month 29b. Siana une Name and address of person who ed cause of death (Item 23a) (Type Print) Glen Burnie 20161

State Registrar 31. Date filed (Month, Day, Ye

distrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For AMEND#22 per FH State of Maryland / Department of Health and Mental Hygiene 1 - State of 6/2011 AAO HEALIH DEPT. OMH Certificate of Death Registrar AMEND#22 per FH State of Maryland / Department of Health and Mental Hygiene												
			Registrar 1. Decedent's Name (First, Middle, Last)	Cen	ificate of D	eatn	2. Date of De	Reg. No.	2011	3. Time of Death		
	Physician/ Phillip Currie May 30 Day 201									10:40A M		
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		۱	122 Chesapeake Ave		Annap	napolis			nne Ar	cundel		
Funera Directo			5. Social Security Number $\begin{array}{c c} 6. \text{ Sex} & 7. \text{ Age (In yrs. last birt)} \\ 215-16-6262 & 1\% \text{ M } 2 \text{ F} & 89 \end{array}$	If Under 1 Year Months 0ays	Hours Min.	8. Date of Birt (Month, Da		9. Birt Mar	hplace (State or Foreign Intry) Yland			
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Baltimore, Maryland Z1Z13-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exam <u>iner must be notified at</u>	3	<u> </u>	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No 1 No 1 Yes, Give Year or Dates 1 9 4 5 – 4 6	1	Yes 2X No		nouri, etc.)	S	Black, White pecify: B1	Lack		
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JIVISION OT al or Attending Pt s after death. I Director: After th ad in by the funeral	Cortificator		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, stree	et, factory, office		28f. Location (\$ City or Tov		reet and Number or Rural Route Number, n, State)			
DIVISION OT VITAL RECORDS, P.O. BOX 06/00 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	diog	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, (Check 2 Medical Examiner: On the basis of examination and/c	or investig	gation, in my opinio	n, death occurred at	the time, date a	and place, a	and due to the	cause(s) and manner stated.		
o the vithin of the comple	Ž	Ž	only one) 3 Certifying Nurse Practioner: To the best of my know 29b. Signature and the of certifier	/ledge, de	eath occurred at the 29c. License		e, and due to th		and manner as signed (Month			
			1. Kuleovoti M	D	Doc	54903		6	1 /	011		
#4.			30. Name and address of person who completed cause of death (Item 23a) (Dr. Frederick Karkowski 139 0)	(Type, Pr	lomuns I	Sland Rd	Anna	polis	md.	2/401		
S Regis	tate		21 Date filed (Month Day Year) 00 De feature Company		ake)	,			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Frederick Loux Crothers 754 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Meritus Medical Center Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Sex 1120 M 2 □ F **Funeral** Months Hours Min. May 20, 1936 Philadelphia .PA Director 218-78-6855 75 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at. 10a. State 10d. Inside City Limits 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13532 Red Brick Lane 21742 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working भ Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h permit. Page 1 and 2 should be Department of Health and Ments Important; If item 27 is marked any injury or near ပ Harold Loux Crothers Gertrude M. McCullum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rayma J. Ham / Niece 18734 North Ridge Dr., Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematorium June 7, 2011 Smithsburg, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home Signature of Funeral Service Licenses Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardiae disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Year Pregnant at time of death been signed by the should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 🗌 Yes 2 🗌 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 **N**O ျင 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title o certifier 29c. License number 29d Date-signed (Month, Day, Year,

Registrar

DHMH 17 Rev 7/2009

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

HMACK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ 7:27 BETTY CASTLE JUNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE 8. Date of Birth
(Month, Day, Year)
June 4, 1937 9. Birthplace (State or Foreign 6. Sex If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 🗆 M 2 🖾 F Months Days Hours Maryland Director 214-34-9684 Usual Residence of Deceden or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** 1 🗆 Yes 2 🖵 No Maryland Boonsboro Washington 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 be 23a U.S.A. 21713 8915 Lums Lane items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status "natural", or iten edical Examiner Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White 3 Widowed 4 Divorced Completed al Hygiene. I other than "natura vent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cosmetics Representative Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental I ၉ William Oscar Lum Virginia ELizabeth Hammersla 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 8915 Lums Lane, Boonsboro, Maryland 21713 John K. Castle/husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott
once, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/10/11 Boonsboro, Maryland Boonsboro Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old Natinal Pike, Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Pnysician/ STAGE LIVER DISEASE END Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iiniury the Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 2 No 1 Nes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this 28b. Time of 27. Manne of Death 28a. Date of injury 28d. Describe how injury occurred 28c. Injury at Certificate; (Month, Day, Year) Natural work 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and the of cert

State Registrar KAHNTROFF, MD 22

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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BALTIMORE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ **a** M Virginia Colliflower Susie 2011 June 8:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Williamsport Williamsport Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Social Security Number 7. Age (In vrs. last birthday) Country)
Maryland 1 🗆 M 2 Hours 2/5/192 Director 219-14-7578 88 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral 10924 Roessner Ave. 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 2 No 1 Yes Specify: White 3 ₩idowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Domestic Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Leo Poffenberger Rhoda B. DeLauney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1112 Mountain View Circle, Hagerstown, MD 21740 Vicki Vaughn / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 6/9/2011 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery Hagerstown, Maryland 21. Signature of Funeral Service L 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition CARCINOMA METASTATIC COLOLI Physician/ MONTH Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence ory Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): physician Physician/Medical Box 68760 the as attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the a Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at Certificate: 1 Matural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar A-127174N

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who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) June 20 T Physician/ 9:15 A M Cunningham Ann Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Washington Williamsport 17101 Miner Ave. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1272271947 Mary land 1 M 2 M F 63 Director 212-50-9035 Usual Residence of Deceden 3a or 28a-f show t be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State within 72 hours after death with the Maryland Director 1 Yes 2 No Williamsport Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a Funeral 21795 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death wift Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Examiner must I 17101 Miner Ave. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Addiction Counselor Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Brown Domer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17105 Miner Ave., Williamsport, MD 21795 Larry M. Cunningham / Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 6/10/2011 Hagerstown, Maryland Rest Haven Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 1601 Pennsylvania Ave., Hagerstown, MD 21742 S.M. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to or as a consequence of **Examiner** Sequentially list conditions, Examine Due to lor as a consequence of Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year signed by the a ☐ Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been sit completed filled in by the funeral director, page 2 should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 3 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Natural Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of pers on who completed cause of death (Item 23a) (Type, Print 3424

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amended #23a perMD FCHD KS 6/6/Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Alvie N. Covell Medical 2011 6:40P 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Northampton Manor Frederick 5. Social Security Number 8. Date of Birth (Month, Day Ye Sept. 4, 6. Sex 1 M 2 D F **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days Hours , 1920 Mary land 217-16-2409 90 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States Funeral 5 Glade Road 21793 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 2X No 3 ₹ Widowed 4 ☐ Divorced 1 Yes 2X No Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Vice President & Manager Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alonzo Covell Bessie Wachter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Covell / Son 5 Glade Road, Walkersville, MD 21793 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 5/31/2011 Frederick, Maryland Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a. Pak 1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Uremia 2 Crust disease or condition resulting in death) **Medical** Due to (or as a consequence of) xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Acute Renal Failure Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Box 68760 attending p for use as t 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year the 1 Yes 2 L 9 Unknown 9 Unknown P.0. Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed irector, page 2 should be de 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, PLEURAL EFFUSIONS Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No director, Be 26. Place of Death (Check only one) 2/ No Hospital မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Z Natural 5 Pending after death. Director: Af Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Fune completed f within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) N32171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 L GOUGH RICHARD POBOX 328 WALKERSVILLE, MD

DHMH 17 Rev 7/2009

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Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** 9:38A.M 29 2011 May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick 212 Apples Church Rd. Thurmont 8. Date of Birth (Month, Day, Year) 06/22/1959 Birthplace (State or Foreign Country) 1 Year Days Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months 1 □ M 2 🖺 F MD 51 Director 214-82-8729 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evolution counts be inclined at 1 ☐ Yes 2 1 No Director MD Frederick Thurmont 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21788 Funeral 212 Apples Church Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 2 White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irma Connor Edward Carey Cale, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 212 Apples Church Rd., Thurmont, MD 21788 Colin Crowder / husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) 6/2/2011 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failute. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** theroscieroti disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to (or as a consequence of) ri any, leading to immediale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a the burial-1 Division of Vital Records, P.O. Box 68760, Physician/Medical been signed by the attending p should be detached for use as t IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months?
1 □ Yes 2 ■ No
9 □ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has t e 2 s autopsy performed? Yes 2 No 2 X No within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag uctive 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 5 Residence 6 ☐ Other (Specify) 1XYes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation Injury 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Schree 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Year 0630A.M YOUNTA CHOI 2011 136 Medical . County of Death Montgomery 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🔯 F Months 47 SEBT. 8. 1963 Korea none Yrs Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10c. City, Town or Location College Park 10a. State 10d. Inside City Limits Director Maryland | Prince George's 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20740 Korea Funeral 4712 Cherokee Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2X Married \$ Asian If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education Student Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ukim Shin Jung Hyun Choi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 4712 Cherokee Street College Park, Maryland 20740 Do Kim -husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Norbeck Mem. Gardens 1 XBurial 2 Cremation 3 Removal from State 6/16/2011 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, 4400 Powder MILL Road Beltsville, Corold Maryland 20705 pal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of): a Acute disease or condition Medical resulting in death) Examiner Sequentially list conditions if a y, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Directs for as a nonsequence of attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Tes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 M No Other: 1 Tyes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No completed filled in by the 2 Accident Investigation ☐ Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Medical Examiner: On the basis or examination and or investigation, many opinion, seath second at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signatur@and title of certifier 29d. Date signed (Month, Day, Year) D0063703 06/14/201 2 7600 CARRULL AVENUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SABYASACH WAR TAKOMA PACK, MD 20912

State Registrar 31. Date filed (Month, Day, Year)

2011

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			For State Registrar				-	tificate of			Reg. No	011	19764
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-	Medic Examir				rive street and number)			4b. City, Town,	or Location of Dea	ath	4c. Co	ounty of Death	
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	Funeral Director		5. Social Security Nur 391-42-61	r If Under 24 Hr Hours Mir		1943		hplace (State or Foreign intry) WI					
	and show	ō	Usual Residence of D 10a. State	10b. County		10c. City	, Town or Loc	cation					10d. Inside City Limits
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	th the	ral D	10e. Street and Numb					10f. Zip Code			Ü	n of What Cou	•
	ath w	nue	9065 Cabi	n Court	12. Was Decedent	Ever in ITS	13 V	20736) Hispanic Origin? (Specify Yes or No-		ed Sta	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mertial Hygiene. if Health and Mertial Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by F	1 Never Marrie 3 Widowed 4		Armed Forces	?	li li	Yes, specify Cul	oan, Mexican, Pue	rto Rican, etc.)		Black, White	
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ylaı	ld be Menta arkec	잍	Leonard A	. Patri	ck				Helen	Bermann			
Maryland	shou h and 7 is m traum	Ш	19a. Informant's Nam					-	t and Number or F				Code)
	and 2 s Health tem 27		James Dei		ısband	20b. Pl		Cabin (sition (Name of	Court, Ov	vings, ML Date		tion - City or	Town State
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altii	permit. Page Department of Important: If any injury or once,		21. Sign three CF		A	,							ert, P.A.
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	uted Id ansit	Examiner	cause. Enter Underly Cause (Disease or iir that initiated events	ring 🌃	с.								
	be executed sician and burial-transit	cal Ex	resulting in death) La	est	Due to (or as	a consequ	ence of):						
09289	cate b physion the b	edic			d								
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the beautiest of the completed filled in by the funeral director.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectop 4 ☐ Pregnant at time of death 5 ☐ Other				Ectopic pregna Other (specify)					23d. Date of delivery Month Day Year	
P.O.	requires that the de been signed by the should be detached		Part II. Other signific	ant condition	s contributing to death	but not resu	ulting in the u	nderlying cause (given in Part 1.	23e. Did t	obacco use	contribute to	the cause of death?
ds,	quires en sig ould b	ted								_ 12X	Yes 2 🗆	No 3□Pr	obably 4 🗆 Unknown
Records,	law re has be je 2 sh	Completed by								24a. Was auto		24b. Were aut prior to c death?	copsy findings available completion of cause of
H.	sician: The law i certificate has t irector, page 2 s		25. Was case referred	I to medical	1			26	Place of Death (Ch	1 🗆 Yes	2 No	1 ☐ Yes	2 No
of Vital	Physician: 7 r this certifica gral director, p	To Be	examiner?	•	Hospital:	tient 2 🗀 I	ER/Outpatien	To	her.	Home 5 Resi	dence 6	Other (Speci	(fy)
of	ding Phy h. After thi funeral		27. Manner of De th	5 Pending	28a. Date of inj (Month, Da	ury	28b. Time of injury	28c. Inju		28d. Describe			
ion	Attendii death. ctor: Ai y the fu	tifica	2 Accident 3 Suicide	Investiga	tion			M 1	Yes 2 No	-			
Division	ital or At urs after or ral Direct lled in by	al Certificate:	4 Homicide	determin	ed 28e. Place of in building, e	tc. (Specify)		eet, factory, office		City or To	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	To the Hospital or Attenc within 24 hours after death To the Funeral Directors, completed filled in by the	Medical	29a. Certifier (Check 2 only one)	Medical Ex-	hysician: To the best of aminer: On the basis of lurge Practioner: To the	examination	and/or invest	igation, in my opi	nion, death occurre	d at the time, date	and place, ar	nd due to the c	ause(s) and manner stated.
	To with		29b. Signature and At	le of certifier Las UN	(Armen	li,	w	29c. Licen	se number 0524	401	July	signed (Month	2011
10.	7 (30. Nam and address	s of person wh	no completed cause of	death (Item	23a) (Type, P	rint) 10	1.0		100	1/1/	10 20100
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	Sta Registr		o Date filed (IMOHIII),	July, Italy	32. Regist	ra s Signati	uie A	bow.	1			,	

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 8:25 AM Lewis Wingert Duffey, Jr. Sume Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Hagerstown Meritus Medical Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign ocial Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 219-46-1298 Aug. 1945 65 Marviand **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Hagerstown Maryland Washington County 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be 23a Funeral U.S.A. 21742 1117 Beechwood Dr. hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iten edical Examiner r Armed Forces? Black, White, etc. 1 Never Married 2 XMarried þ Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) **1**2 Radio Station Disc Jockey Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hazel Lorraine Shoemaker Duffey Lewis Wingert Duffey, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1636 Alphin Way Greencastle, PA 17225 permit. Page 1 and 2. ...
Department of Health an Important: If item 27 is Susan L. Valentine-daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park 6-6-2011 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ com Arten disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner schedie Sequentially list conditions, Examine Diserto for as a porsequence of cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events POROVED BY MEDICAL EXAMINER resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 CERTIFICATION IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 No been signed by the sahould be detached 9 Unknown a 🗌 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Direm Rolling 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? That intection Autophotopic Sondien 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA s after death.

I Director: After this of in by the funeral di this 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: or Attending Ivatural 5 Pending 1 🗌 Yes 2 X Accident May 2,2011 Investigation 6 Could not be unknown M subject fell out of bed 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 11116 Medical Campus Rd. Hagerstown, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours aff

To the Funeral Di

completed filled in hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) unt Mo JUNE 3, 20 11 D (8019 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 21741 HAGERS TOW W DATT 340 MILL ~ 0 31. Date filed (Month, 1977) 6 2011 32. Registrar's Signature State park Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast 2. Date of Death Day Physician/ 29 MM Leonard Albert DANIEL 2011 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 102 North Edgewood Drive Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Nov. 6, 1920 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Min. 1 🛣 M 2 🗆 F 141-12-9145 90 Yrs. Virginia Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must he notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 Yes 2X No 10e. Street and Number 10g. Citizen of What Country? 21740 Funeral 102 North Edgewood Drive U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black White etc ð 1 Never Married 2 Married 1 X Yes 2 No Saltimore, Maryland 21215-0036 1952 1 Yes 2x No Specify: white Specify: 3 X Widowed 4 Divorced 1963 Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Coast Guard pilot Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marcelle Carre Leonard E. Daniel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 102 North Edgewood Drive, Hagerstown, Maryland 21740 Frances Constable - daughter Department of Health Important: If item 27 any injury or other tronce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Hagerstown Crematory June 6,2011 Hagerstown, Maryland 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Minnich Funeral Home Signature of Funeral Service License 22. Name and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Due to for as a consequence of) if any, leading to immediate cause. Enter Underlying Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 SB IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Month Year 4 ☐ Pregnant at time of death g ☐ Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by pe (1 Yes 2 No 3 Probably 4 Highwayn 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy page perform death? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Hospital 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 1 Yes 4 Nursing Home 5 Aresidence 6 Other (Specify, After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 24 hours after deat Funeral Director: the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and titl 29d. Date signed (Month, Day, Year) 6.6-2011 0050362 Name and address of person who completed cause of death (Item 23a) (Type, Print) Ove Hogerstown m021742 JW-10+1 13424 vanla tono State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month DAWSON TANNIE 7:20 A M 2011 MA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner YOUNG 1135 FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours 219-48-655 1 □ M 2 1 F Min 64 Director 24, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10h County 10c. City. Town or Location d other than "natural", or Items 23a or 28a-f show event, Its Medical Examinar must be notified at 10d. Inside City Limits FREDERICK Director 1. Yes 2 No FLEDERICK MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? PLACE 1135 YOUN 6 USA 21702 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 ☐No Specify þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PROVIDER HOME CHILD CARE permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be TACKSON WILLIAM E. DORSEY NETTIL G 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 BROADWAY ST FREDERICK (dau) ILSHIA PLUMMER MO Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SMITHSBURG MA, MAY 12 2011 SMITHOBURG CROW. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ROLLING FUNDAR HOME 21. Signature of Funeral Service Licensee my X. SOUTH ST FREDERICK 21701 110 WCST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Due to (as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an After this certificate has autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LANE RABOBRUR 21702 Sabiha Mohiuddin MDINO BAULGHMANIS 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

Darke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 28,2011 Physician/ 8:11pm Ekpo 0. Eyo Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince Georges Bowie Bowie Health Center 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth If Under 1 Year Social Security Number Sex 1 M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Nigeria (Month, Day, Year) July 28,1931 Months Days Hours 79 Director 551-04-6276 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2X No MD. Prince George's Hyattsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20782 USA 6609 23rd Ave · death v 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 No Black White etc. 1 Never Married 2 Married ģ Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: Specify: Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) <u>Professor / Archaeologi</u>st Education 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fis marked of Ako Esien Ekpe Okpo Eyo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Hyattsville, MD 20782 6609_23rd Ave Augusta T. Eyo / Spouse Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 X Removal from State Lagos, Nigeria 7/1/2011 4 Donation 5 Other (Specify) Vaults and Garden 21. Signature of Finer Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 23d Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION PNEUMUNIA **Chysician** disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 11PHAGIA MOWITE Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events YEARS requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Physician/Medical P.O. Box 68760 as attending IF FEMALE yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Live Birth 2 - Fetal death Ectopic pregnancy Month Year Pregnant at time of death the 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by SACRAL DECUBITUS 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Division of Vital Records, After this certificate has been HYPERTENSION Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? ANEMIA To the Hospital or Attending Physician: The L within 24 hours after death. To the Funeral Director: After this certificate h 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 005143 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 1200 ANNAPOLIS RD #232 GLENN DALE MD 20769 BITOYE OKEOWO DARCY State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 9:05 Allen Wilbert Ecke1 29 May 2011 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mallard Bay Care Center Dorchester Cambridge 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 20, **Funeral** Months Days Hours 1 ☑ M 2 □ F 220-12-0764 93 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10c. City, Town or Location show ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Exa a in the most by natities at 1 □Yes 2 No Director Dorchester Cambridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code with 213 Sandy Hill Road 21613 USA Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event Black, White, etc. 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White 9 WWII 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) director hospital personnel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Cordes Eckel Pauline Jamison 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grason John Allen Eckel 213 Sandy Hill Road, Cambridge, MD son 21613 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State Crematory of Delmarva 6/1/11 Delmar, DE 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Ligenses 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Vascular **Physician** erebia Da. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physiclan; The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 DUnknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To within 24 hours after death,

To the Funeral Director: After thi
completely filled in by the funeral of 27. Manner of Leath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30 700

State Registrar 31. Date filed (Month, Day, Year)

JUN 0 8 2011

Johnson



ddress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 2320 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Davs Hours Months Director 1/17/1921 Missouri 495-30-7832 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits Director MD Annapolis Anne Arundel 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21403 USA 603 Beach Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates. WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Heating and AC 01 Plumber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James C. Eaves Mary L. Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beach Drive Annapolis, MD 21403 Mary Catherine Eaves Wife 603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 06/08/2011 Crownsville,MD 21032 Maryland Veterans Signature of Funeral Service Licensee 22. Name and Address of Facility 12 Ridgely Ave Hardesty Funeral Home P.A. Annapolis MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ARTERY CORONARY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HYPERLIPIDEMIA Esquentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit CHRONIC OBSTRUCTIVE PULMONARY DISEASE that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Medical HYPERTENSION Box 68760 IF FEMALE: Physician/ 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 Ho Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature

State Registrar

DHMH 17 Rev 7/2009

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2003 Medicil Phung St 100 ANNA Priss

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ME

Registrar's Signature

ANDREW GOLDON

JUN 0 6 2011

31. Date filed (Month

State Registrar

31. Date filed (Month, Day,

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DHMH 17 Rev 1/2001

Ed #216. ROCKHUR, MD 20852

n who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 14 Day 2011 Year DONALD **JAMES** ELLIOTT JUNE 10:55 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Chester River Manor Chestertown Kent Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours 1 🛛 M 2 🗆 F Director bctober 12 1919 New York 120-01-4247 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Massey Kent 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12063 Galena Rd. 21650 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White 3 XWidowed 4 ☐ Divorced Specify Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) High School Math Teacher Senior High School permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other 1 any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Roy Elliott Mabel LeBelle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2515 Shepperd Rd. Faye Carpenter (daughter) Monkton, MD. 21111 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 DeBurial 2 Cremation 3 Removal from State 6/20/11 Lakeview Memorial Sykesville, MD. 4 Donatton 5 Dother (Specify) Galena Funeral Home of Stephen L. M00510 118 West Cross St. Galena, MD. 21635 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cadse (Final Physician/ FAILURE TO disease or condition mouth Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death ed by the Unknown 9 Unknown signed I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OSTEUMYELITIS, ARM Completed 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been s funeral director, page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 2 **A** No 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ပ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending in 24 hours after death.

In Euneral Director; Af pleted filled in by the fu 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed within 2 3 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0041587 WW. 2011 161

State Registrar Helen A.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Chestertown, MD. 21620

122 Speer Rd.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

Noble.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June June Day 2011 0945 A M Kose Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Laurelwood Care Center Cecil E1kton Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 □ M 2 🏋 F FEB 1 Pay, Year 23 New Jersey 88 Director 146-16-1064 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 🏋 Yes 2 □ No Maryland Ceci1 E1kton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 100 Laurel Drive 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 2 X No 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Miguel DeCato Angelina Fania 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cassandra Fow/Daughter Corsica Avenue, Bear, DE 19701 20a. Method of Disposition
1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Brandywine Valley Cremation Care 2011 4 Donation 5 Other (Specify) Wilmington, DE 22. Name and Address of Facility Hicks Home for Funerals, P.A. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD esma 23a. Part r. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ wei Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed en Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 Yes 2 No 2 2 N 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No Director: A Accident
Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours aff

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 1)0026183 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sachde 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			FOI	ate of Maryland	/ Departme	ent of Health and	Mental Hygier	пе	
		4	State Registrar		Certifica	te of Death	Reg.	10 m	19774
	Physicia Medic	al	1. Decedent's Name (First, Middle, Last)	el Faulk	ner		2. Date of Death Month	Day 2011	3. Time of Death 1 9:36 AM
	Examin	er	4a. Facility Name (if not institution, give street 412 Shephev	A AVE	(Town, or Location of Death	l	4c. County of Death	rester
Ī	Funeral Director		5. Social Security Number 6. Sex 1 M M	7. Age (In yrs. last	birthday) If Und Month	der 1 Year If Under 24 Hrs. s Days Hours Min.	8. Date of Birth (Month, Day, Yea		hplace (State or Foreign intry)
	land show dat	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	Town or Location				10d. Inside City Limits
	the Mary or 28a-f e notifie	Direc	10e. Street and Number	ster (Cell Dy	idge Zip Code	10g.	Citizen of What Cou	1 Yes 2 ☐ No untry?
	ath with ems 23a must b	Funeral Director	412 Shepher 11. Marital Status 12. W	A Ve /as Decedent Ever in U.S.	13. Was Dec	2(6)3 redent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Amer	ican Indian.
39	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1	rmed Forces? Yes 2 No Yes, Give ear or Dates.	If Yes, sp	pecify Cuban, Mexican, Puert 2 Specify:	o Rićan, etc.)	Black, White	
21215-0036	72 hours n "natur Aedical I	Completed	15. Decedent's Education (Specify only highest grade co.	on mpleted)	16a. Decedent's U (Give kind of v life. DO NOT o	vork done during most of wo	rking 16b	o. Kind of Business I	ndustry
	within ygiene. her thai it, the N		12	ollege (1-4 or 5+)	Vice	Precidea-	t I	Santi	ng
Maryland	ld be filed Mental Hy arked oth atic event	To Be	17. Father's Name (First, Middle, Last)	Faulkn	ex	18. Mother's Nat	me (First, Middle, Maid E WE E	en Surname) 2 TOAC	1
Mar	d 2 shoulafth and 27 is m	l lu	19a. Informant's Ime/Relationship (Type-Pr	int) Wite	19b. Mailing Addre	ess Street and Number or Ru	ral Route Number City	or Town, State, Zip	Code) 2. MDZ/43
nore,	Page 1 and nent of Heal ant: If item iry or other	,	20a. Method of Disposition 1 Burial 2 Cremation 3 Remo		ce of Disposition (A		Date 200	Dia Cityon	Town, State
Baltimore	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	2424 1 0 0 0 0	22. Name	and Address of Facility.	urran E	>mhlue	" Funeral
	402 00		23a. Part I. Enter the disease, or complication shock, or heart failure. List only one cau	ons that caused the death. I	Do not enter the m	ode of dying, such as cardiac	or respiratory arrest,	ibivege,	Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequen	arrhy	thing			Onset and Death
	Examiner	je je	Sequentially list conditions, b. —	Dilated	card	ionyopathy	·		10 years
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00	e be executed ysician and ie burial-transi	ical	resulting in death) Last	Due to (or as a consequer					
6876	ertificat ding ph se as th	/Mec		yes, outcome of pregnanc				23d. Date of del	ivery
. Box 6876	ne death o	Physician/Med	in the past 12 months?	Live Birth 2 Fetal of Pregnant at time of dea				Month	Day Year
s, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions contribu	Mellitus	ing in the underlyin	ng cause given in Part I.			the cause of death?
Division of Vital Records,	law requ has beer ge 2 shou	Completed					24a. Was an autopsy performed	prior to o	topsy findings available completion of cause of
al Re	sician: The law certificate has rector, page 2	Be Co	25. Was case referred to medical examiner?			26. Place of Death (Che	1 🗌 Yes 2 🗷		2 🗆 No
of Vii	Physic r this ce eral dire	은	1 ☐ Yes 2 No	1 Inpatient 2 EF 8a. Date of injury 28	8b. Time of	DOA Other: 4 Nursing I	Home 5 Residence		ify)
ion (ttending death. :tor: Afte r the fune	Certificate:	1 Matural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year) 8e. Place of Injury - At home	injury M	work? 1 \(\superset \text{Yes} 2 \superset \text{No} \)	28f. Location (Street	t and Number or Pu	ml Poute Number
Divis	ital or A urs after ral Direc		4 🗆 Hornicide determined	building, etc. (Specify)			City or Town, St	tate)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director Atter this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Examiner: Conly one) 3 Certifying Nurse Pra	n the basis of examination a	ind/or investigation,	at the time, date and place, in my opinion, death occurred courred at the time, date and p	at the time, date and pl	lace, and due to the o	cause(s) and manner stated.
	To To a		29b. Signature and title of certifier	Il.	N.D.	29c. License number \$\int 50 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	29d.	Date signed (Month)	n, Day, Year)
(5/8		30. Name and address of person who complete Mark Malkus,		3a) (Type, Print)	(t . t .	ambrida	e MD	21613
	Sta Registr		31. Date filed (Month, Day, Year) JUN 02 2011	32 Registrar's Signatur	park	/		3	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State o	f Marylan	•				and M	ental Hy	giene			
			Registrar	- Lasti	Certificate of Death							Reg. No	UII.	19775	
	Physicia	an/		1. Decedent's Name (First, Middle, Last)							Date of Dea Month	ath 28, 20	Year	3. Time of Death	
	Medical Examiner Willie A. Flood 4a. Facility Name (if not institution, give street and number)						4h City I	TOWN Or	Location of	of Death	May		J. I. unty of Death	7:30 A M	
-	Z		10811 Electr	is. Ony,		Lanha					George's				
	Funeral	Г	5. Social Security Number	ast birthday)	If Under 1 Year If Under 24 Hrs. 8 Date of Birth			th	9 Rinth	place (State or Foreign					
	Director	l	227-20-1798 Usual Residence of Decedent	1 Ϫ M 2 □ F	85	Yrs.	WOITEIS	Days	Tiours	1	March 5	, 1926	o Nort	Carolina	
	and show	Į.	10a. State 10b. County		10c. City	y, Town or Lo	cation						1	10d. Inside City Limits	
	Maryll 28a-f otifiec	rect	DC						Wash	ingt	on			1 ☒ Yes 2 ☐ No	
	n the		10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cou	ntry?	
	th with ms 23 must	Funeral Director	5515 5th Stree						2001			Unit	ed Sta	ites	
'	er dea or itel niner	by Fu	11. Marital Status 1 □ Never Married 2 ☒ Mar	Armed For	dent Ever in U.S ces?	5. 13. V	Vas Decede f Yes, specif	ent of His fy Cubar	spanic Orig n, Mexican	gin? (Speci , Puerto R	ify Yes or No- ican, etc.)		Race - Americ Black, White,		
036	rs afte rral", Exan	ed b	3 Widowed 4 Divorced	If Van Chu	9	1	☐ Yes 2	™ No	Specify:			Spec	cify: Afri Amer	can	
21215-0036	e filed within 72 hours after death with the Maryland ital Hygiene. So or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decede (Specify only highe	nt's Education st grade completed)		16a. Deced	lent's Usual aind of work			of working			of Business In		
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d 2	filed within al Hygiene. d other than vent, the N	Be	17. Father's Name (First, Middle, I	ast)]	Syster	ns U			First, Middle,		Govern	ment	
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ary	should be and Ment is marker raumatic e	15	19a. Informant's Name/Relations			19b. Mailin	g Address (Street a	nd Numbei			er, City or Town, State, Zip Code)			
	1 and 2 sof Health item 27 other tra		Eula Flood - Wi	.fe		1	5th S				hingto		20011		
lore	ye 1a nt of H : If ite or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from S	State 20b. Pl	lace of Dispos emetery, crem) J	Tune 201	ite 3	20c. Location	on - City or To	own, State	
Baltimore,	iit. Pae irtmer irtant: njury	9	4 Donation 5 Other (S		/	Harn								Maryland	
Ba	permit. Page 1 a Department of F Important: If ite any injury or ot	8	21. Signature of Funeral Service L	Steven.	1,25	4		enni	ng Ro	oad N	wart Fu E Wasl	hingto	Home, n, DC	Inc. 20019	
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that can nly one cause on cac	used the death h line.	n. Do not ente	r the mode	of dying	, such as c	cardiac or i	respiratory arre	est,		Approximate Interval Between	
and a	Ph,sician/ ∫ Medícal	l i	Immediate Cause (Final disease or condition resulting in death)	_ a. 17/1/2	eros de	vo lu	Car	rch	wa	Sun	lor o	lisea	n	Onset and Death	
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	icate be executed g physician and is the burial-transit	dical Examine	Cause (Disease or iinjury that initiated events	c											
	ate be executed ohysician and the burial-transi	al E	resulting in death) Last	Due to (o	r as a conseque	ence of):									
760	physic physic the b	Ψ.		d					_						
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30X	e atter	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregna	irth 2 🗌 Fetal ant at time of de		Ectopic pre Other (spec						Date of delive Month	Day Year	
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rds	equire	eted	199100121	nny							1 ∐ Y	es 2□No	3 Prob	pably 4 🗹 Unknown	
eco	rsician: The law is certificate has the lirector, page 2 s	Completed	24a. Was an autopsy performed?									sy	24b. Were autopsy findings available prior to completion of cause of death?		
<u> </u>	I Physician: The lav		25. Was case referred to medical					00 DI-	(D. II	(0)	1 🗆 Yes		1 Yes	2 🗌 No	
Zit?	ysicia is cert direct	To Be	examiner? 1 Yes 2 No	Hospital:	npatient 2 🗆 E	B/Outpatient		Othor	e of Death				thou (Const.)	Hospice	
oţ	ng Ph fter th meral	ij	27. Man r of Death 1 Natural 5 □ Pendin	28a. Date of		28b. Time of injury		. Injury a work?			d. Describe ho			nospice	
<u>o</u>	tendii leath. tor: Ai the fu	itica	2 Accident Investig	ation			М	1 🗆 Y	es 2 🗆 N	No					
Division of Vital Records,	or At after of Direction by	Certificate:	4 ☐ Homicide determi	28e. Place o	f Injury - At hon g, etc. <i>(Specify)</i>	ne, farm, stree	et, factory, c	office		28	f. Location (St. City or Town		nber or Rural	Route Number,	
Ω	spital nours neral filled		29a. Certifier 1 X Certifying	Physician: To the bes	st of my knowle	dge, death or	cured at the	e time	date and ni	lace and o	tue to the caus	se(s) and mai	nner as state	1	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	(Uneck Z L Medical E	caminer: On the basis Nurse Practioner: To	of examination	and/or investig	ation, in my	/ opinion	death occ	urrad at the	a time date an	d place and	due to the cou	ea(e) and manner etated	
	Noth		29b. Signature and title of certiler	20_			29c. L	icense r	number				ned (Month, D		
			-	Line				001	5368	81		0/1	14		
2	10			ho completed cause 1835 Unive				ite	208	Hyat	tsville	, Md.	2078	3	
	State Registra	_	31. Date filed (Month, Day, Year) JUN 0 7 2011	Server 32. Reg	gistrar's Signatu	ake									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No... Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Ol Maurice Lee 5:00 PM Grove JUNE 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Hours Oct.3I, 1926 84 220-18-3369 Director Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a, State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16505 Virginia Ave. A-210 21795 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Examiner Armed Forces?

1 X Yes 2 If Yes, Give , or Black, White, etc. 1 Never Married 2 X Married ģ 2 No 1944-Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Completed White 1946 Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 2 should be filed within 72 l th and Mental Hygiene. 7 is marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Computer Programmer Railroad traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isaac N. Grove Mary Louise Mentzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health a item 27 i Audrey Grove - Wife 16505 Virginia Ave. A-210 Williamsport, MD 21795 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other? 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depation 5 Other (Specify) Greenlawn Mem. Park June 6,2011 Williamsport, Maryland Signatur of Funeral Service Osborne Afaneraly Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sk, or heart failu Immediate Cause (Final k, or heart failure. List only one cause on each line Interval Between 5 69515 Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PREUMONIA Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Pheumo THOR Cause (Disease or iinjury ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical RESPIRATORT or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the a d be detached f 1 ☐ Yes ∠ □ 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 brunnon, 2 DISGASE 2 No 3 Probably 4 Unknown been sic should ! Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 autopsy After this certificate har funeral director, page death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗌 No မူ 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director; A sleted filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 3 [29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 10062006 -18+ 30. Name and address of poson who completed cause of death (Item 23a) (Type, Print) JW- 5 MEDICAL CAMPUS ROAD HOM OUSTOWN WIRSOM mo 31. Date filed (Month. State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 2011 8:50 AM Dorothy Jean Gerhart Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown 17964 Garden Lane Apt. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec • 5 , 1936 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Hours Min. 74 Maryland Director 214-34-2201 Usual Residence of Decedent 28a-f shov 10b. County 10d, Inside City Limits death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a State 10c. City. Town or Location Director 1 Yes 2 X No Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21740 USA 17964 Garden Lane Apt. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced White Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Switchboard Operator Hospital Be permit. Page 1 and 2 should be file.
Department of Heatth and Mental Hy important: If item 27 is marked oth any injury or other the state of the sta 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Viola John Raymond Bloyer Cora Needv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17964 Garden Lane Apt. 2 Hagerstown, Maryland 21740 Harold W. Gerhart - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hill June 7,2011 Cemetery Hagerstown, Maryland Gaborne Afroné Fally Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ chireche disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Dav Pregnant at time of death I signed by the a 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has I filled in by the funeral director, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 X No ည 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 🗌 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month

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or mack

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May **Physician** 2¹/₂ 2011 BEATRICE MOSELLE GREGORY 4:22 Ам /Medical 4a. Facility Name (If not institution, give street and number)
St. Catherine's Nursing Home 4c. County of Death 4b. City. Town, or Location of Death Examiner Emmitsburg Frederick 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year) July 24, 1917 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 □ M 2√ F Maryland 215-76-7317 93 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show The Medical Examples must be notified at 1 ☐ Yes 2√☐ No Director Maryland Frederick Emmitsburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10536 Welty Road 21727 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 Tes 2 No Specify Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done di life. DO NOT use retired) (Specify only highest grade completed) during most of working Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home othert other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nd Mental å George Washington Johnson Alta Beatrice Walter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 M. Denise Early / Daughter 10536 Welty Road, Emmitsburg, MD 21727 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once 4 ☐ Donation 5 ☐ Other (Specify) St. John the Evan. Cem. 5/31/11 Forest Glen, Maryland 21. Signature of Funeral Service Licen ROBERTO Eddre DATLEY & SON FUNERAL HOMES, P.A. Tε 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 6 Maril /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included exacts) Examiner attending physician and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. been signed by the should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performe certificate CONO-ES 1 ☐ Yes 2 ☐ No 1 Yes 2 No : After this certifica e funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation death. Director: / 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide after within 24 hours a To the Funerei 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 27, 10

State Registrar

31. Date filed (Month, Day, Year)

NAY 3 1 2011

32. Registrar's Signat

registrar's Signature for the same

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amended # 5perFH FCHD KS 6/2/11 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAY BERTRAND WIDDER GRAY 2011 5:33P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY 5-Social Security Number 577-28-9558 597-28-955 6. Sex 1 M 2 □ F 7. Age (În yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Min. 06/18/1924 86 PADirector Usual Residence of Decedent 28a-f show 10b County at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified MONTGOMERY ROCKVILLE 1 Yes 2 No MD ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 16504 GEORGE WASHINGTON DR. 20853 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 1 Never Married 2 Married 2 Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE "natural" Completed 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) SYSTEMS ANALYST IBM 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN CAMPBELL GRAY GOLDIE WIDDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4909 CHAMPLAINE CT., JEFFERSON, MD 21755 SHARON D. GALLEHER/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) STAUFFER CREMATORY 06/01/2011 FREDERICK, 21. Signature of Fineral Service Licensee 22. Name and Address of Facility .0 BOX 86 HILTON FUNERAL HOME BARNESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ₽nysician/ ATHEROSCLEROTIC CARDIOVASCULAR DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of): ∡xaminer NON INSULIN DEPENDENT DIABETES Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): bunial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical to the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Yes 2 No detached 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Yes 2 No certificate 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No မ 1 Inpatient 2 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A Investigation 6 Could not be the Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pleted filled in by 4 Homicide determined Medical ertifying Physician: If the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie I have to the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Light of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Cheal within 2.

To the F 29b. Signature and title of certifi who completed cause of death (Item 23a) (Type, 30. Na e and address for rson 31. Date filed (Month, Day, Year) State strar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Donna Lynn Hicks $201\tilde{1}$ 8:12 June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital of Cecil County E1kton Cecil Social Security Number 6. Sex Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye Country) 1 □ M 2 🗓 F Months Hours 454-15-1143 Director 56 Sept. Texas Usual Residence of Decedent is marked other than "natural", or items 23a or 28a-f show aumatic event, the M-dical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and: if item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Midical Examiner must be notified at ury or other traumatic event, the Midical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits Maryland Cecil North East 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1014 West Old Philadelphia Road 21901 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2X Married Completed by Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Seven Years Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Mary Alice Curran Leonidas Dunlap Robinson, III 19a. Informant's Name/Relationship (Type, Print)
Perry L. Hicks (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1014 West Old Philadelphia Rd., North East, MD 21901 Department of Health Important: If item 27 any injury or other tronce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State West Chester. 06/08/11 R.A.Ferris & Co., Inc. 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania Signature of Funeral Service Licen 22. Name and Address of Facility Lee A. Patterson & Son Funeral Perryville, Maryland 21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Arc disease or condition Medical resulting in death) Due o (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death Year the detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 16.00 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy 2 No Yes 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital Other: 2 X No ၉ 1 Tyes 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 🗹 Natural injury 5 Pending ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of exar prination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michele Y. Delpier, M.D., Union Hospital of Cecil County, Elkton, Maryland 21921

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Examiner Name (if not institution. give street and number) 4b. City, Town, or Location of Death 4c. of Death Date of Birth **Funeral** Months 1 M 2 F Hours Director Ko Usual Residence of Decedent "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ✓ Yes 2 ☐ No 01 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status edent Ever in U.S 14. Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or ģ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Year or Dates 24 Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO 1001 use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business Industry College (1-4 or 5+) Be 17. Father's Nar (First, Middle, Last) ပ nant's Name/Relationship (Type, 20b Place of Disposition (Name of 200 2 Cremation I from State Rema 5 Other Donat 21. Sigr any art 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on/ac sed the death. Do not enter the mode of dying, such as cardiac or Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nemo rehage stral disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pardiomyopathe 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 X No completed filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural Natural iniury 5 Pending work?
1 Yes 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D69048 6/4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registrar's Signature

MD

21921

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JUNE 6:05 PM MICHAEL MILTON HENDERSON 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE'S QUEENSTOWN 226 HARBOR LANE If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F JUNE 28 Year 1943 IOWA (**Director** 67 573-56-5105 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at once. Director 1 Yes 2 No QUEENSTOWN OUEEN ANNE'S MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 21658 226 HARBOR LANE 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give WHITE 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) UNITED STATES Elementary/Seconday (0-12) College (1-4 or 5+) COLONEL MARINE CORPS 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ALYCE CHRISMAN WILLIAM HENDERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONNA ANN HENDERSON/ WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other pla QUANTICO NATIONAL CEMETERY 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) JUNE 13. TRIANGLE, VA 21. Signature of Funeral Service Licenses Name and Address of Facility
LOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ne lanome Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last as the burial-tran Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) ned by the a detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? performed certificate 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၣ 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of s after death. 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation the 1 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide determined within 24 hours al

To the Funeral D

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Marse Provious: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only on Signatur 29d. Date signed (Month. Day, Year, D37064 10+1 of death (Item 23a) (Type, Print) DEH 31. Date filed (Month 32 Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / 1/2011 Physician/ Year 1:04 Ernest H. Halpern Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) NY 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 X MM 2 [] F Min. Months Hours 472971928 109-22-6788 83 Director Usual Residence of Decedent 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho ed other than "natural", or items 23a or 28a-f sho event, the M diral Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XXIo MD Anne Arundel Annapolis 10e Street and Number 10f Zip Code 10g, Citizen of What Country? Funeral 1309 Van Buren Dr. USA 21403 12. Was Decedent Ever in U.S.

Armed Forces?

AX Yes 2 □ No 1953If Yes, Give Year or Dates. 1955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chemist Dept. of Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Emmanuel Halpern May Hoffman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) and 2 s Health item 27 Annapolis, MD 21403 Marilyn Halpern 1309 Van Buren Dr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ð cemetery, crematory or other place) 0 XXurial 2 Cremation 3 Removal from State 6/3/2011 4 Donation 5 Other (Specify) Annapolis, MD Kneseth Israel 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 ď 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ripheral Vascu disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 3 months vo t Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death Yes ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signed I should be det þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ Inpatient 2 🗆 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1, 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number Marke OBrie 0056208 10*1

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

2002

32 Registrar's Signature

pleny , 520.

Annashis MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

MD

Mark obvien

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 30, Physician/ Arnin William Hinkle 12:34 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10121 Greenock Rd. Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🕅 M 2 □ F Months October 14, Pennsylvania 171-26-7932 Director 75 1935 Jsual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits s 23a or zu-nust be notified a' by Funeral Director 1 🗆 Yes 2 💢 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? LISA 10121 Greenock Rd. 20901 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married "natural", or Exami Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Completed Year or Dates. 53-62 er than "natur the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Software Programmer Computer and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arnin E. Hinkle Margaret Walsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Virginia E. Hinkle-wife 10121 Greenock Rd., Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Washington Crem. June 3, 2011 Laurel, Maryland Signature of Fun a Service Licensee Fleck Funeral Home, INC. 7601 Sandy Spring Rd., I M0123 Laurel, Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) vears Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ò in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 X No 2 🗌 No Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 🗌 Yes 2 V No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Natural within 24 hours after death. To the Funeral Director: A 1 🔲 Yes 2 No Accident Investigation Could not be the 1 Suicide 3 ☐ Suiciue 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 Certifying Nurse Practioners. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D34032 June 2, 2011 s of person who completed cause of death (Item 23a) (Type, Print) Jeanne P. Asher, M.D., 3720 Farragut Avenue, Kensington, MD 20895

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUN 03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20 oKa ·vian Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Pice Hinne entreville ueen Veen Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗹 F Days Months Hours Min. Director shov 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No 28a-f Sonville 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? Funeral or items 23a Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Specify. Completed Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) ပ Harrison narles urner and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number Department of Health a Important: If item 27 is any injury or other tra aMMON Corner srason Vi arles Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Robin Son emetery. 4 ☐ Donation 5 ☐ Other (Specify) 6 ason Ville 21. Signature of Funeral Service Licenses s of Facility HOME Henry, Funeral MD-21613 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1/ Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CANCER disease or condition resulting in death) UETARS ung Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of) the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Ves icate has been sig , page 2 should b 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform After this certificate filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 $ot\!\!\!/$ Other (Specify) 2 မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSP!ce 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? within 24 hours fter dearh.

To the Funeral Lirector. A completed filled in by the fu 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and tle of certif 29d. Date signed (Month, Day, Year) D39887 Le H 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David H. Smith, M.D. 8221 Teal Drive, Easton, MD 21601 31. Date filed (Month, Day, Year) State

Registrar

JUN 08 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May Month 2011 26. EMMA MAE HUMERICK 10:10 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Northampton Manor Nursing Home Frederick Frederick If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) March 23 1 🗆 M 2 😾 212-24-6050 1929 Maryland **Director** Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 506 East Main Street 21788 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. 3 X Widowed 4 ☐ Divorced Specify: Completed White Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+ Supervisor Shoe Factory other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Andrew Kuhn Mary Alice Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14733 Sabillasville Road, Thurmont, MD 21788 Timothy O. Humerick / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) any injury or Resthaven Mem. Gardens 6/1/2011 Frederick, Maryland 21. Signature of Funer Servi e License ROBERT E. DAILEY & SON FUNERAL HOMES, P. 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.

Immediate Cause (Final HSLTIC STENDSIS Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): _xaminer Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed bunal-transit and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant Unknown Day 5 Other (specify) Month Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 has performe 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 24 hours after death. Funeral Director A 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signator d title of certifie 00062223 ddress of person who completed cause of death (Item 23a) (Type, Print) FREDERICE, MD 196 TJ Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death Physician/ June 10 ay 2011 James Luther Hilaman 1445 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Cecil 238 West Main Street E1kton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min. March I4, Maryland 213-68-2326 56 Director Usual Residence of Decedent 28a-f show 10b. County 10a State 10c. City, Town or Location 10d Inside City Limits ral", or items 23a or 28a-f shor Examiner must be notified at Director 1 X Yes 2 No Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 238 West Main Street 21921 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ş 1 Never Married 2 👿 Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 2 should be filed within 72 hours afte th and Mental Hygiene. 27 is marked other than "natural", traumatic event, the Medical Exar If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Julie Dorsev William T. Hilaman, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is a any injury or other traumonce. Karen Hilaman/Wife 238 West Main Street, Elkton, MD20a. Method of Disposition 20b. Place of Disposition (Name of June T 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Rose Bank Cemetery 2011 4 ☐ Donation 5 ☐ Other (Specify) Calvert, MD Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 22, Name and Address of Facility 103 W. Stockton Street, Elkton, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ending physician and use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Pregnant at time of death Month Day signed by the a d be detached for 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed?

Yes 2 No death? 1 Yes 2 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Be 2 Hospital 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred **N**atural iniury work?
1 Yes 2 No 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Ju chel the MU DOF823 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) maist FILCO 2 Md 2194 22 HIH HS

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Death Reg. No.										
Physici		Decedent's Name (First, Middle, Last		3. Time of Death							
edical Exami	iner	Etsegene		issa			June 2, 2	011	2248 nrs		
		4a. Facility Name (if not institution, give NB Georgia Ave @ Regina	·		4b. City, Town, Silver Sp	or Location of Dea ring	th	4c. County of Montgor			
Funeral		Social Security Number 6. Se	7. Age (In yrs. I	ast birthday)	If Under 1 Y	ear If Under 24H	rs. 8. Date of Bi	rth (MM/DD/YYYY	9. Birthplace (State or Foreign		
Director		215-87-0774 1	M 2XF 24	Yrs		ays Hours I wil	" Februa		CountryEthiopia		
<u> </u>		Usual Residence of Decedent									
A		,							10d. Inside City Limits 1 X Yes 2 No		
yland r-f sh	ţoţ	Maryland Montgome 10e. Street and Number	ery	Silver	Spring 10f. Zip Code		13	I0g. Citizen of Wh			
e Mar or 28;	ire	13225 Holdridge F	Pood		2090			Ethiop:			
r death with the Maryland or items 23s or 28s-f show any must be notified at once.	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	S 13 Wa		Hispanic Origin? (§	Specify Yes or No		e - American Indian, Black,		
eath v item	al le	1 X Never Married 2 Married	Armed Forces?			oan, Mexican, Puert			e, etc.		
ffer d		3 Widowed 4 Divorced	1 Yes 2 A No If Yes, Give Year or Dates:	1	Yes 2 X	No specify:		Specify:	Black		
ours a	d by	15. Decedent's Education (Specify on				pation (Give kind of life. DO NOT use re		16b. Kind of Bu	isiness/Industry		
6 n 72 h en "n	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	_	•		·	1	_		
within giene.	Ë	17. Father's Name (First, Middle, Last)	years	Assist	ant Day	y Care Wo		Day Ca	re Center		
al Hyg	Be C	Abebe Hurissa	Bedassa				Abera	Maiden Surname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	To B	19a. Informant's Name/Relationship (T)		19b. Mailing	Address (St			nber, City or Tow	n, State, Zip Code)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic event, the Medical Examiner must be notified at once.	Г	Gashaw Bedassa	(uncle)	13225	Holdr:	idge Road	;Silver	Spring,	Maryland 20906		
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other fraumati		20a. Method of Disposition	20b.	Place of Dispos	ition (Name of	cemetery,	Date	20c. Location -	- City or Town, State		
Pages ent of nt: H		1 Nation 2 Cremation 3 Denation 5 Other Specify:	Removal from State Kot	ebe Dag	mawi K	ulbi St. J	une 11,	Addis	Ababa,Ethiopia		
alti mit. 1 partm ury o	1	21. Signature of Funeral Pervise Licens	ee 2	22. N	lame and Addre	ess of Facility R.	N. Hort		any Morticians,		
E F C F W	(Sandulch &	Starle	Inc	.;600 1	Kennedy S	treet, N	.W.;Wash	ington,D.C.2001		
Physician		23a. Part I. Enter the disease, or compli failure. List only one cause on each		. Do not enter th	ne mode of dyir	ng, such as cardiac	or respiratory arr	est, shock, or hea	art Approximate Interval Between Onset and		
/Medical Examiner	8 9		Multiple Injuries						Death		
		or condition resulting in death)	due to (or as a consequence o	f):							
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated C	oue to (or as a consequence o	6).							
760, ficate be executed g physician and the burial - transit		events resulting in death) Last L dd.	rue to (or as a consequence o	1):							
760, icate be executed physician and the burial - transi	/Medical	UNPENDED	AMENDED					1 118			
760 icate b	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg	nancy				23d. Date of	delivery		
68 certifi nding ise as	ian	past 12 months?	1 Live birth 4 Pregnant at time of de	-44		3 Ectopic pregn	ancy	Month	Day Year		
Box 68760, death certificate be he attending physic d for use as the bur	Physician	1 Yes 2 No 9 V Unknown	9 Unknown	2 □ Oti	ner (Specify)			1			
brds, P.O. Box 68 w requires that the death certif s been signed by the attending should be detached for use as		Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying caus	e given in Part I.	23e. Did to	obacco use contri	ibute to the cause of death?		
res th	d by						1 Yes	s 2 ✔ No 3	Probably 4 Unknown		
v requ	lete						24a. Was autop		Were autopsy findings available prior to completion of cause of		
ecc he lav ate har	Completed							rm <u>ed</u> ? d	leath? ✓ Yes 2 No		
Entification, p	BeC	25. Was case referred to medical	<u> </u>		26.Pla	ce of Death (Check	-				
of Vital Records, P.O. ng Physician: The law requires that th After this certificate has been signed by meral director, page 2 should be detach	TO B	examiner? 1 ✓ Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient	3 DOA	Other Nursi	ng Home 5	Residence 6	Other: Scene		
ing Ph		27. Manner of Death 1 Natural 5 Dending	28a. Date of Injury (Month, Day, Year) Jun 2, 2011	28b. Time of Ir 2238 hrs	· · _	njury at Work?		how injury occurre lestrian struck			
sior trend death. ctor: y the	ätic	2 ✓ Accident 5 Pending Investigation	n			Yes 2 ✔ No					
Division tall or Attendir rs after death.	Certification:	3 Suicide 6 Could not b			t, factory, office	e building, etc.	or Town, S	itate)	er or Rural Route Number, City		
Ospita hours uneral y fille		29a Certifier	(Specify) Major Road						Ave, Silver Spring, MD		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one) 2 ✓ Medical Examiner:	 n: To the best of my knowledge On the basis of examination are 								
To wit	Mec	29b. Signature and title of certifier	and manner stated.		29c. Lice	nse number		29d. Date signe	ed (Month, Day, Year)		
		111 V. B.	11.00		0.0	C.M.E.		June 3, 201			
- ,		30. Name and address of person who co	ompleted cause of death (Item	23a)				<u> </u>			
- 6			sistant Medical Examin		. Baltimore	Street, Baltimo	ore, MD 2122	23			
	ate	31. Date filed (Month, Day Year)	32. Registrar Signatu	all							
Regist	TC I	JUNU (LUII /	- 1- 17	1							

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homas Johnso	n	1- For State Registrar			d / Depar		f Health an			ne	20	Party (mil.)	1978
Physici	an/	Decedent's Name (First	st, Middle,Last)							te of Death			3. Time of Death
Medical Exami	iner		ALAN JOH							ne 3, 201			1118 hrs
		4a. Facility Name (if not in 520 South Main		eet and numbe	er)		4b. City, Town, or North East		Death		4c. County	of Death	
Funeral		5. Social Security Number	f 6. Sex	7. /	Age (In yrs. las	t birthday)	If Under 1 Yea			ate of Birth	(MM/DD/YYYY	9. 10	RTH(STAST ANYLAND
Director		216-56-7789	1 <u>X</u> M	2F	59	Υr	Months Day	s Hours	Min. (08/30,	/1951	Colo	MANY LAND
roa.		Usual Residence of Dece 10a. State 10b. (County		10c. City, T	own or Loca	tion						10d. Inside City Limits
and show	_	MARYLAND	CECIL			NORTH	EAST						1 XX Yes 2 No
3 72 hours after death with the Maryland 1 "natural", or items 23a or 28a-f sho	Director	10e. Street and Number					10f. Zip Code			100	g. Citizen of Wh	nat Coun	ntry?
the h		520 SOUTH	MAIN STR	EET, Al	PARTMEN	NT 110	21901			Ī	UNITED	STAT	res
th with	Funeral	11. Marital Status 1 XXNever Married 2		Armed Force	nt Ever in U.S.	. 13. W	as Decedent of Hi	spanic Origin' n, Mexican, Pi	? (Specify Yuerto Rican,	es or No- etc.)		- Americ	can Indian, Black,
er dea		3 Widowed 4	Divorced If Ye		2 XX No	1	Yes 2 X No	s specific			Specify:	7.77	TTT
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Baltimore, permit. Pages 1 a Department of He Important: If ite		21. Signature of Funeral				22.	Name and Address	s of Facility			ERAL HO		
	_	23a. Part I. Enter the dise	ase or complicati	one that cause	ad the death. F								LAND 21901 Approximate Interva
Physician Medical		failure. List only one	cause on each li	ne.			ne mode of dying,	Sucr as card	iac or respir	atory erres	it, silock, of flee	ait	Between Onset and Death
ixaminer		Immediate Cause (Final or condition resulting in d			hot Wound sequence of):					_			
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t the d	Physi	Part ii. Other significant			ath but not resi	ulting in the	underlying cause (given in Part I.	23	Be. Did toba	acco use contri	bute to t	he cause of death?
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leco	E								_	perform ✓ Yes 2	ed? d	leath?	s 2 No
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of Vital ng Physician After this certi	P	1 ✓ Yes 2 1	_	, , , , , , , , , , , , , , , , ,		R/Outpatien					esidence 6		Scene
on of ading Ph. th. After t	ë	1 Natural 5	Pending	28a. Date of In FOUND:	Year) F	8b. Time of OUND:		ry at Work? Yes 2 ✔ No	l Subje	ect shot s	w injury occum self	Ba	
Division tal or Attendi rs after death.	ficat	2 Accident 3 Suicide 6	Investigation	May 31, 201 28e. Place of		1128 hrs ne, farm, stre	et, factory, office b			cation (Str	eet and Numbe	er or Rur	al Route Number, City
Divi	Certification:	3 ✓ Suicide 6 4 Homicide	Could not be determined	(Specify) M	ulti-Family	Apt.					te) Street Apt. 1		
Hosp 24 ho Func etely fi		10110011011	ying Physician:										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical			the basis of ex manner stated		l/or investiga			ed at the tir				
	Σ	29b. Signature and title of	Certifier	11			29c. Licens O.C.I				29d. Date signe June 4, 201		th, Day, Year)
		30. Name and address of	+ W/1	Interd and and	death /Itam 0	30)	0.0.1	IV. L.					
4		Jack Titus MD.					Baltimore Stre	eet, Baltim	ore, MD 2	21223			
St	ate	31. Date filed (Month, Day	(,Year)	32. Registr	rar's Signature	, ,							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0405 20 1050-Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 82 Hours Min 1 X M 2 - F (Month, Day, Year) 8/6/1928 578-36-4855 Yrs Director VA Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes XX No MD Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3913 Calawasse Rd. 21037 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give ı "natural", or item edical Examiner n 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. WWII þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after White 1 Yes 2 KNo Specify: Specify Completed 3 Widowed 4 Divorced Year or Dates than "natural F 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) سرد برانان. سرد zz is marked other than ه د traumatic وهمت Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Heavy Equipment permit. Page 1 and 2 should be fileo. Department of Health and Mental Hy, Important: If item 27 is marked *** any injury or other **** once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျှ Fred S. Johnson Sr. Ursula Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 3913 Calawasse Rd. Edgewater, MD 21037 Shirley Johnson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Cheltenham Veterans 6/9/2011 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate END shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death STAGE Physician/ OBSTRUCTIVE ULMONAR CHRONIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying ARDIOM YOPATH Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniury been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of resulting in death) Last Be Completed by Physician/Medical NEVMONIA Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERLIFI DEMIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has funeral director, page 2: performe 2 No Yes 2 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes မ 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) s after dec. 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 065292 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Mo

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Registrar's Signatu

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Parknay

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 2, 2011 Pay Physician/ 7:40 p M William Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign **Funeral** Country) 1 M 2 F Hours **Director** December 8, 1916 213-12-1395 Usual Residence of Decedent show 10d. Inside City Limits with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 No Calvert Prince Frederick MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 492 Stamper Court 20678 Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, Armed Force 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Specify. 3 Divorced 4 Divorced Completed Black Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Custodian **Public Schools** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ant of Health and Menta it: If item 27 is marked y or other traumatic e Mary Smith William Jones Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 492 Stamper Court, Prince Frederick, MD 20678 Jeanette Jones - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Department Important: If any injury or Ernestine Jones Cemetery June 11, 2011 Chesapeake Beach, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sewell Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NENWONI Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Yea Pregnant at time of death the detached 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🛣 No 1 Yes 2 X No director. 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes Other: 2 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation the 1 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

dew 5

HOV Shunder Sidny 100 Hospital
31. Date filed (Month, Day, Year)
32. Registral Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrate Signature

1-8 2011 Leven B. Lawl

Registrar

Road

Prince Fredericki

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Flice 05 Physician/ 0375AM , Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arunde1 Medica1 Arundel Center <u>Annapolis</u> 8. Date of Birth (Month, Day, Apr 25 Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) Social Security Number Funeral Days Hours 1 M 2 TF 73 Yrs. Apr 938 Director 215-32-6817 Usual Residence of Decedent or 28a-f show notified at 10d, Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked the than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 X No Lothian Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 905 Bayard Rd. 20711 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc 1 Never Married 2X Married Yes 2 X No þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black If Yes Give Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant State of Maryland 12th \cap Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 James W. Blake Sr Alverta Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James H. Jackson(Husband) Bayard Rd. Lothian. Md. 20711 905 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ₩ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Adams U.M. Church 6-4-11 Lothian, Md. M Marrie Reaches Seof RecilitSons Mortuary, P.A. 21. Signature of Funeral Service Licenses any 21401 922 Forest Dr. Annapolis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Coronar disease or condition Medical resulting in death) Due to (or as a consequenc Examiner abete Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown P.O. s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an n5 On page 2 s autopsy performed 1 ☐ Yes 2 ☐ No this certificate Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 34% Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes funeral 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funera 5 Pending 1 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 90 wens ville Rd, West River, MD 20778

Registrar DHMH 17 Rev 7/2009

State

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JUN 06 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Year <u>Grafton Johnson Sr</u> May Medical 2011 430 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Arunde1 Anne 8. Date of Birth (Month, Day,) June 25 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 1 💢 M 2 🗆 F Days Hours Min Year) Director Yrs 216-14-5859 88 Maryland Usual Residence of Decedent 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 ☐ Yes 2 😾 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral within 72 hours after death with 2222 Mulberry Hill Rd. 21409 USA items 12. Was Decedent Ever in U.S. Armed Forces?
1 ▼ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, trais marked other than "natural", or i traumatic event, the Medical Examin Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Divorced 4 Divorced Completed **Black** Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) United States and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11th n Chauffeur Academy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည t. Page 1 and 2 should be tment of Health and Men rant: If item 27 is marke Harrison Johnson Clara Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 230 N. Pindell Ave Grafton Johnson Jr(Son) Annapolis, Md. 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Maryland Veteran 6-6-11 Crownsville, Md. 2Wmme are seef F&ilitySons Mortuary, 21. Signature of Funeral Service Licensee ann Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Uniterlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Š in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by KIDNER 1 Yes 2 No 3 Probably 4 Unknown VALVULAR 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? certificate 1 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 2 မ 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Cal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Pragion: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of c 29d. Date sig ٩ ned (Month,

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD.

31. Date filed (Month, Day, Year JUN 0 7 2011

900 W. Baltimore Street, Baltimore, MD 21223

Assistant Medical Examiner

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Physician/ 06 2011 3:00 AM Evelyn Mary Kanigosky 06 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ceci1 68 Brownfield Loop 8 Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** (Month, Day, 05/05 1 □ M 2 🕱 F 88 170-20-9555 **Director** Usual Residence of Decedent or 28a-f show notified at 10d Inside City Limits 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2 K No PA Columbia Bloomsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral USA 29 Saluki Road 17815 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S 11 Marital Status "natural", or ite Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 White 1 Yes 2 X No If Yes, Give 3 K Widowed 4 Divorced Completed Year or Dates the Medical 16a Decedent's Usual Occupation 16h Kind of Rusiness Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own home and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Anna Shopenski Robert Maurer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2...
Department of Health and Important: If item 27 is 490 Fowlersville Road, Bloomsburg, PA 17815 Linda K. Baker 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State Casimir's Cem. 06/10/11 West Mahanoy Twp., PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility R.T.Foard Funeral Home, P.A. 21. Signature of Funeral Service Lip any in 111 S. Queen Street, Rising Sun, MD 21911 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Phylician/ disease or condition resulting in death) Medical Due to (or as a consequent Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence oi): and -transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month in the past 18 months?
1 Yes 2 No Year Pregnant at time of death signed by the a d be detached f 9 Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the squse of death? þ Unknown 1 Tyes 2 No 3 Probably Completed peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has l autopsy perform 24 hours after death.

Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA Residence 6 Other (Specify) ပ 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: J Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifier 29d. Date signed

Registrar

State

30. Name and a

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2,2011 Johanna Kerr June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center <u>Annapolis</u> Anne Arundel 5. Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign Country) Ohio **Funeral** Days Hours Months Min. 0972771934 Director 219-26-7799 76 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho appropriant: If item 27 is marked other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel 1 Tes 2 No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 103 Hearne Road Unit 701 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland 04 Social Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Eugene James Kerr Doris Geraldine Jeffries 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kerry Sobel Niece 1844 Shore Drive Annapolis, MD 21401 Baltimore, 20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crematory 20c. Location - City or Town, State 06/06/2011 Glen Burnie,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A. Annapolis, MD 21401 Jaki 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ysician and le burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 ending phys attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached for Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Onknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No ည 1 🔲 Inpatient ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural I hours after death. uneral Director: After the function of th 5 Pending 1 Tes 2 No 2 Accident 3 Suicide 4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medidal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and add

31. Date filed (Month, Day, Year)

JUN 06 2011

ress of person who completed cause of death (Item 23a) (Type Print)

sistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 1016 AM Corey Matthew Kitchen MAY 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Meritus Medical Center Hagerstown Washington County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign 6. Sex 1 AM 2 □ F 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Nov. 7, 2005 219-73-5491 Maryland Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Marvland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 117 Winter St. 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kenneth L. Kitchen, Jr. Angelina M. Ruck Kitchen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth L. Kitchen, Jr.-father 117 Winter St. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department o Important; If any injury or Smithsburg Crematory 6-6-2011 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home MD 21742 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dilure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ CHNCER BRAIN WITH disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has all director, page 2 death? 2 - N 1 ☐ Yes 2 ☐ No Yes **Director:** After this certifical in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗆 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural (Month, Ďay, Year) 5 🔲 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical 29a. Certifier 🕶 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D0057280 1 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1198 KENLY AVE HAGERSTOWN, MD 21740

Registrar DHMH 17 Rev 7/2009

State

EAVER IR, M.J.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Year Physician/ Month Walter Edward Kohler 10:59AM 2011 Medical June 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Meritus Medical Center Washington County Hagerstown 5. Social Security **1702** 175–20–1720 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days 1 XM 2 □ F April Day 3,1926 Pennsylvania 85 Director Yrs. Usual Residence of Decedent "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Maryland Washington County 1 🗆 Yes 2 🔀 No Maugansville 10f. Zip Code 10g. Citizen of What Country? Funeral 13914 Green Mountain Dr. 21767 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give 1944 Year or Dates. 10 Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Truck Mfg. and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Walter T. Kohler Florence Kloss Kohler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Stealey-daughter 71 Redwood Dr. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State St. Joseph Cemetery 6-13-2011 Johnstown, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home MD 21742 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the presence, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filied in by the funeral director, page 2 should be detached for use as the burnal-transit attending physician and for use as the burial-transit resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: signed by the attendin 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Chronic arem 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 e arthrops 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D44996 2011 une +1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20311 lappans Rd boomsbow 31. Date filed (Month State

Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May Day 2011 Year Josephine O. Keech 21 3:40 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Potomac Valley Nursing Home Rockville Montgomery **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 X Months Hours August 19, 1922 Ohio 291-12-2066 88 Director Usual Residence of Decedent show 10a. State 10b. County death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Rockville 1 XX Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? by Funeral 20850 14431 Traville Gardens Cir., Apt.104D United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Bookkeeper Accounting of Health and Mental Hygie item 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Blaine Keifer Helen Downs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Keech / Son 2301 Chilham Pl., Rockville, MD 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State Rest haven 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State June 2011 4 Donation 5 Other (Specify) Frederick, Maryland Memorial Gardens 21. Signature of Fun dervice ricenses Resthaven Funeral Services, Skkot Cody P.A M01237 Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the disease, o shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, liv one cause on each line. Interval Between Onset and Death Weeks Immediate Cause (Final disease or condition Physician/ _{a.} Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) Exami sician and burial-transit certificate be executed Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Year Pregnant at time of death 2 XX No Hospital or Attending Physician: The law requires that the detect thous after death.

Funeral Director: After this certificate has been signed by the seted filled in by the funeral director, page 2 should be detached. g Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Pulmonary Hypertension 1 Tes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 🔀 No Other: 1 🗌 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pendina 1 Yes 2 No 2 Accident
3 Suicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature nd title of certifie 29c, License number 29d. Date signed (Month, Day, Year) May 21, 2011 D 38262 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8

DHMH 17 Rev 7/2009

State

Registrar

A. Mendhiratta

31. Date filed (Month,

32. Registrar's Signature

2401 Research Blvd., Ste. 330, Rockville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY H9320L 20 12:30PM Medical Facility Name (if not institution, give street and number)
LEASANT VIEW HURSING
4101 OLD MATIONAL 4b. City, Town, or Location of Death 4c. County of Death Examiner 4101 INTAIR ARROLL 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 - F Months Days Hours Min Washington, D.C Director 578-40-5399 1932 Nov Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Brown myortant: If item 27 is marked other than "natural", or items 23a or 28a-f show any joiny or other traumatic event, the Medical Examiner mice has a or 200. 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Frederick Mt. Airy Maryland 1² Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1114 Poplar Grove Court 21771 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1953 Black, White, etc. 1 Never Married 2 KM Married Completed by 2 No white If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. 1955 Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Exterminating Business owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eleanor Linthicum Herbert F. Kolley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Kolley - Wife 21771 1114 Poplar Grove Court, Mt. Airy, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 XX remation 3 ☐ Removal from State 5-27-2011 Frederick, Maryland Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Sign ure of Funeral Service Licensee 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) todi Medical Due to (or as a cons mence of ∠xaminer Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner signed by the attending physician and d be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequer Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 Nunknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2: autopsy performed? Yes 2 No 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cellifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 29b. Signature and title 29d. Date signed (Month, Day, Year, MN 120057574 2711

State Registrar

(0

32. Refistrar's Signature

7133 Mill Run Drive, Derwood, Maryland

20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmed Heshmat, MD

MAY 31

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Barbara Ann Kriemelmeyer Рм 7:30 Medical June 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 [X F Days Hours Min. Country) Canada 215-58-8732 68 Director Yrs. Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director W۷ Jefferson Harpers Ferry 1 Yes 2 X No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 1785 Job Corps Road 25425 USA items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", Completed Specify. 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry المالية. ما Hygiene. مع than "ح (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Housewife Homemaker Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ralph Edward MacDonald Alberta May Mackinnon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Kriemelmever - Husband 1785 Job Corps Road, Harpers Ferry, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hagerstown Crematory 20c. Location - City or Town, State 1 Burial 2 🕅 Cremation 3 🗆 Removal from State 6-4-2011 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Eack les-Spencer & Norton Funeral Service Licensee

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. & Norton Funeral Home V 25425 Approximate Interval Between Onset and Death Immediate Cause (Final Ph_ician/ Po disease or condition Medical resulting in death)) Med. Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (a a consequence of): Exami Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be P.O. Box 68760 the attending properties for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death the Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, the Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed? certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🕅 No Other: ပ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 🗆 this thin 24 hours after death.

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mpleted filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 🗌 Yes 2 No Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) tille of certi 29b. Signature a MDD 65378 Name and address of person who completed cause of death (Item 23a) (Type, Print) HEARUNO

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

Year,

JUN

32. Regist ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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John Comments of the Comments		2395 Bear Den Road 5. Social Security Number 6, Sex	7 4-0	(In yrs. last birthde		derick	der 24 Hrs.	8. Date of Birt	Freder	cick	place (State or Foreign
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permit. Pa Departme Important any injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice see	O	Mt. Oliv			6/6/2 ₩¥		Frederic		
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Medical Examiner		resulting in death)	Due to (or as a	consequence of):	21.10	1.07	Inla	1	pr Jung		Yes
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at 1 9 Unknown		5 Other (spec				Mor	ith	Day Year
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the Hos hin 24 h the Fur	Medical	(Check 2 Medical Examiner:	On the basis of exa	amination and/or in	estigation, in my	opinion, death	occurred at	the time, date a	nd place, and due	to the cau	use(s) and manner stated.
or with		29b. Signature and tipe of certifier	1 des	n/mi	> 29c. Li	icense numbe	r N S	1	29d. Date signed	(Month, I	Day, Year)
		30. Name and address of person who comp	leted cause of dea	ath (Item 23a) (Typ	e, Print)	11646	<u> </u>		Y	-+-	
/ () Stat		31. Date filed (Month, Day, Year)	32. Registar	s Signature	1						
Registra	ir	JUN 0 3 20	Ken	eur B.	park						

11-04348 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Brayden Dayebga Kehbila State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Da June 9, 2011 Kehbila 1655 hrs **Medical Examiner** Brayden Dayebga 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 14 Director 216-89-1017 1X M 2 F Oct.26,2010 Marvland Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location Maryland Prince George's Mount Rainier 1 X Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3313 Chillum Road 20712 United States Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 X Never Married 2 Married 1 Yes 4 Divorced If Yes, Give Yeer 3 Widowed 1 Yes 2 No specify: Specify: Black ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 0 none none 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Claudia Bih Ningmuh Be Kehbila Evonce Beyuga and Mental 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ nt of Health and it: If item 27 is nther traumat 3313 Chillum Road Mount Rainier, MD 20712 Kehbila Evonce Beyuga -father 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place? 1 X Burial 2 Cremation 3 Removal from State George Washington Cerretery 6/13/2011 Adelphi, Maryland Donation 5 Other Specify. 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a SUDI (Sudden Unexplained Death In Infancy) Immediate Cause (Final disease ≟xamine≀ or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and trau Physician/Medical AMENDED 23a, 27, 28a-f, per me, g919 9-23-11 sm ☑ UNPENDED by the attending physician ached for use as the burial law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Day 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 1 Yes 2 No 3 Probably 4 V Unknown Completed s been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed page 1 🗸 Yes 2 No certificate 1 ✓ Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: this 1 🗸 Yes 28d. Describe how injury occurred After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 1 Yes 2 X No Unknown 5 Pending death. fd 6-9-11 fd 4:21 pm 2 ___ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State 6801 Riggs Rd. #2-2 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide determined Found at babysitter's Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

31. Date filed (Month, Day Year) State Registrar

29b. Signature and title of certifier

Theodore M. King, Jr., MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

June 11, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Willard Worthy Lough June 2, 2011 7:05 p. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 6215 Ripley Road LaPLata Charles Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) **X**□M 2□F (Month, Day, Yea Months Days Director 203-22-7423 80 1931 West Virginia Jsual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location Director Maryland Charles LaPLata 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6215 Ripley Road 20646 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced White Korea Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Refriq Mechanic U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental H permit, Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 Is marked any injury or other traumatic ev Luther Clyde Lough Genevieve Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennie L. Lough Wife 6215 Ripley Rd., LaPlata, Md. 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) June 10, 2011 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Cheltenham, Maryland 21. Signature of Fundral Service Life Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md 20640 23a. Part 1. Enter the dis shock, or hear failu Immediate Cause (Final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a conseque ce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 🗌 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death
1 Vatural
2 Accident
3 Suicide 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the eleted filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending work? Investigation 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1—Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RB 12+1 0 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Box 68760

Division of Vital

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		Registrar 1. Decedent's Name (First, Middle, Last)			00,0,,,,,,,,,			2. Date of De	eath		3. Time of Death	-
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10a. State 10b. County Maryland Cecil		10c. City, Town o	on						10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
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2 shou th and 27 is m traum:		19a. Informant's Name/Relationship (Typer Faith A. Lee/Wife	e, Print)			,	ind Number or Run 1 , Elkton		er, City or 21921		o Code)	
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permit. F Departm Importa any inju		21. Signature of Funeral Service Licensee	Eusma	ئ	22. Name a	nd Addres	s of Facility Hi Stockton		ie fo	r Funer	als, P.A.	
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To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, farr . <i>(Specify)</i>	n, street, facto	ry, office			(Street and wn, State)		ral Route Number,	
the Hospit in 24 hour the Funera	Medical	only one) 3 Certifying Nurse	er: On the basis of ex	amination and/or	investigation, in	n my opinio	n, death occurred a	at the time, date	and place.	, and due to the	cause(s) and manner stat	ted.
To t To t		29b. Signature and title of certifier			29	c. License				te signed (Mont		
		30. Name and address of person who co Jamil Khatri, M.D					54086 104, E1	kton. M		June 15 1921	, 2011	
Stat Registra		31. Date filed (Month, Day, Year) JUN 2 0 201	32 Alegistra	r's Signature	back		.,	7			····	_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 201^{Year} . TYNYF: 3 2:45 AM BERNADIA CLARICE LOVELY Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth **Funeral** Month, Day, Year February 24 Days Hours 219-13-5036 1 M 2 X F 24 Director MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director MD Prince George's Suitland 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3368 Curtis Drive, Apt.#103 20746 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify. "natural", 3 Widowed 4 Divorced Completed Black Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) 72 Al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) old be file Mental ည of Health and Ments fitem 27 is marked rother traumatic e Cynthia Lovely Bernard Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8700 Pinta Street, Clinton, Maryland 20735 Cynthia Coley/ Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot 3/ Removal from State 1 Burial 2 X Cremation Riverdale Park Crematory 6/10/11 | Riverdale, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service L 11010 5538 Marlboro Pike, Forestville, MD 20747 Patr 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part Approximate Interval Between Onset and Death Immediate Cause (Final OSTEOSARCOMA Physician/ PROGRESSIVE METASTATIC 5 years disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 6 months LUNGS FROM TUMOR OMPRESSION OF Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physiclan for use as the burial Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death To the Hospital or Attending Physician: The law requires that me use within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached. 1 ☐ Yes 2 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown TRACHEA COMPRESSION OF CAUSING 24b. Were autopsy findings available prior to completion of cause of death? DISTRESS/ARREST 24a. Was an autopsy performed? Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h 1 Yes 2 Yo 1 XYes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 100 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0067777 3 12011 ave, ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CENTER DRIVE, BETHESDA, MARYLAND 20892

State Registrar HEMA DAVE

31. Date filed (Month, Day, Year)

O NUL

DHMH 17 Rev 7/2009

32. Registrar's Signature

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

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Examili	er			sted Living		ility			aurel	Location	OI Death				e Geo:	
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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of F0		Licensee	,					_						
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certifi	Be	25. Was case referr examiner?		Hospital:					26. Pl	ace of Dea	th (Chec	k only one)				ASSISTED
r this eral dii	6:1	1 ☐ Yes 2,4 27. Manner of Deat	No th	1 [Inpatie		ER/Outpatie		DOA Otti	4 ⊔ N		ome 5 Resi				かいいんで
ath. :: Afte e fune	cat	1 ☑ Natural 2 ☐ Accident	5 Pendii	ng (Mo	onth, Day		injury	М	work			Zou. Describe	now inju	iry occur	eu	
er des ector by th	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could	not be 28e. Pla			me, farm, si	treet, fac	ctory, office						er or Rur	al Route Number,
irs aft al Dir led in						. (Specify)						City or To				
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Medical	(Check 2	2 🖳 Medical I	Physician: To the Examiner: On the b	asis of ex	kamination	n and/or inve	stigation	n, in my opinio	on, death o	ccurred a	t the time, date:	and plac	e, and du	e to the c	ause(s) and manner stated.
vithin i	Σ	only one) 3 29b. Signature and		Nurse Practione	r: To the	best of my	knowledge	death o	29c. License		e and plac	ce, and due to the				stated. , Day, Year)
> - 0		•	Non.	Anen	>					231	18			-		2011
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141		R.4.B	HOJA	LAJ. MT	0.7	764		nan	n A	4 m	77	La	716	1,	MD	20861
Stat Registra	_	31. Date filed (Mont	th, Day, Year)	3 2011 32.	Registra	r's Signat	ure	1								

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea	se Type or Pri								_	le.	
	-	For State	State of M	arylan				and M	lental Hy	_	001	ı	10000
		Registrar 1. Decedent's Name (First, Middle,	Last)		Cer	tificate o	Death		2. Date of De	Reg. No	0.211		3. Time of Death
Physiciar Medica	_	Gladys		May		Maines			Month June		, 201 ^y	ear -	1:45P M
Examine		4a. Facility Name (if not institution,	give street end number)			4b. City, Town	, or Location	of Death			. County of		
£		1955 Western					t Repu				Cal		
Funeral Director		577-22-9789		e (In yrs. Ia 87	est birthday) Yrs.	If Under 1 Yes Months Day		Min.	8. Date of Bir Month, Da	th 1,2 ^{year)}	1001	Counti	lace (State or Foreign ry) ington DC
nd thow at	5	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation						10	Od. Inside City Limits
ne Maryland or 28a-f show notified at	Funeral Director	Maryland Calve	ert		Port	Republi	.C						1 🗆 Yes 2 🔀 No
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ath wir	nue	1955 Western	Shores Blvd 12. Was Decedent B	Ever in 11 S	: 13 V	206 Vas Decedent o		ain? (Sne	cify Ves or No-		SA		and the state of
or ite	by F	Never Married 2	Armed Forces? ied 1 ☐ Yes 2 🔯		l II	Yes, specify Co	ıban, Mexicar	n, Puerto I	Rican, etc.)		14. Race - Black, 1	America Nhite, e	
urs aff tural", al Exa	ted	3xx Widowed 4 □ Divorced	Year or Dates.		1	Yes 2 X	No Specify:				Specify:	Whit	е
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and Me s mar	ł	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailin	g Address (Stre	et and Numbe	er or Rura	Route Numbe	er, City or	Town, State	e, <i>Zip</i> Co	ode)
nd 2 sl ealth a m 27 i		Patricia Orris	son - Daught	er	1955	Wester	Shore	es B1	vd, Po	rt R	epubl:	ic,	MD 20676
permit. Page 1 and 2 sh Department of Health at Important: If item 27 is any injury or other trat		20a. Method of Disposition 1 1 Sunal 2 Cremation		CE	emetery, crem	sition (Name of natory or other p	lace)		ate		ocation - Ci	-	
artmer artmer ortant injury	-	4 Donation 5 Other (S) 21. Signature of Funeral Service Li	**	Mar		Vetera							m, MD
Dep any	- 1	Amanda M. E	- 1 \ MA	50		3200 Jei	nnifer	Lane	Funer Owin	al H gs,	ome C MD 20	alve 736	ert, P.A.
		23a. Part 1. Enter the disease, or shock, or heart failure. List or	complications that caused nly one cause on each line	d the death	n. Do not ente	r the mode of d	ying, such as	cardiac o	r respiratory ar	rest,			Approximate Interval Between
Physician/		Immediate Cause (Final disease or condition	- Indl	0	Jane	Al	bei	mbe	10				Onset and Death
✓ Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):	0		F-1					
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	ence of):							+	
executed an and rial-transil	Examiner	Cause (Disease or linjury that initiated events	C. Due to for an		2222 201							\bot	
9 P 5		resulting in death) Łast	Due to (or as	a consequ	ence ot):								
ficate I			d										
ending r use a	an/I	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live Birth			Ectopic pregna	ancv				23d. Date of	of deliver	ry
v requires that the death certificate be executed the been signed by the attending physician and should be detached for use as the burial-transit	Pnysician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify)					Month	[Day Year
that the	P Pu	Part II. Other significant condition	ns contributing to death b	out not resu	ulting in the u	nderlying cause	given in Part	· .	23e. Did t	obacco (use contribu	te to the	e cause of death?
quires en sign									1 🗆	Yes 2	No 3	Prob	ably 4 🗆 Unknown
aw rec as bee	Completed	-							24a. Was				sy findings available inpletion of cause of
sician: The law i s certificate has b lirector, page 2 s										ormed?	dea o 1 L	th? Yes 2	2 🗆 No
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ig Phy ter this neral d	:e:	27. Manner of Death	28a. Date of inju	iry	ER/Outpatien 28b. Time of injury	28c. In	jury at		me 5 Resident Rescribe h			Specify)	
tendin leath. or: Aff the fur	Certificate:	1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could r	pation MIA	7	NIA	2 M 1	ork?	No No		1	MA		
l or Att	5	4 Homicide determi				et, factory, offic	e VI A	1	28f. Location (\$ City or Tov			-	Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier 1 Certifying	Physician: To the best of	my knowle	edge, death o	ccured at the ti	ne, date and	place, and	d due to the ca	use(s) ar	nd manner a	s stated	1.
the Hin 24 the Fu		only one) 3 ☐ Certifying	xaminer: On the basis of e Nurse Practioner: To the	best of my	knowledge, d	eath occurred at	the time, date	ccurred at and place	the time, date a e, and due to th	and place ne cause(e, and due to s) and mann	the causer as sta	e(s) and manner stated ted.
vit Sor		29b. Signature and title of certifier	is d.		22.0	29c. Lice	nse number	\neg \neg	,,	29d. Da	te signed (A	fonth, D	ay, Year)
	ŀ	30. Name and address of person w	ho completed cause of d	eath (Item	23a) (Type, P.	rint)	01/	//	4		0/0/	///	·
zw 5		Mahin Y	azdani	255	55 5	olomor	is Is	1 R.	d. Hi	int	noton	wn	mg 20639
State Registra	7	31. Date filed (Month, Day, Year)	32. Registra	s Signati	ure A	back	P				J		20639
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene Amend Item 23aPtII per me,g916,06/20/2011dhb Certificate of Death Reg. No. 1 - For State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year McLaughlin 4:15 Koger MAY 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death n/a Baltimore Cente University of Maryland Medical MD 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Country) MD Months Hours Min. Feb 22. 1954 21862 6811 **Director** 57 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10h Count 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director MD Cumberland Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 38 Utah Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No "natural", Completed 3 Widowed 4 X Divorced white Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than, Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. contruction worker Home Repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ance. ပ Marian (Smith) Fleek McLaughlin Roy E. McLaughlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
38 Utah Avenue Cumberland MD 21502 Katherine Edwards friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ **8**remation 3 ☐ Removal from State Scarpell Funeral Home, P.A. 5/18/201 MD Cresaptown 4 Denation 5 Other (Specify) 21. Sanature of Funeral Service Licensee 22. Name an Scarpe III Fulleral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Ventricular Medical Examiner Se 2572 Sequentially list conditions, if any leading to impediate cause. Enter Underlying Examiner CERTIFICATION APPROVED BY MEDICAL Due to fores e nonsequience ofi requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No ó Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown hed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Coronary ordery disease, MIX3, HTN, Obesity, ESLD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? , Liver transplant 24a. Was an autopsy page performed? Yes 2 No To the Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manger of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pendina work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination allows investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 2011 MD.

DHMH 17 Rev 7/2009

Registrar

120

maryland

University

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Registrar's Signature

JASON GRIESHOBER

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June Physician/ 5. 2011 2:45 P.M Loretta Kav Monterose Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs.

Months Davs Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, Funeral 1 🗆 M 2 🗓 F Days 1 1/1/15/1956 California Director 216-70-8584 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho Director 1 Yes 2 No Prince Frederick Calvert 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 85 Hospital Road 20678 U.S.A. ural", or items 2 I Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Completed 3 Widowed 4 Divorced white Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the disabled 1 and 2 should be filed with if Health and Mental Hygien item 27 is marked other th none none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Patricia Reynolds Danie1 Myers 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Christina A. Beltz, daughter 5330 Majesty Lane, St. Leonard, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 06/06/11 22. Name and Address of Facility Rausch Funeral Home, Sign of Funeral Service Licenses 8325 Mt. Harmony Lane, Owings, MD disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the shock, or heart failure. List only one cause on Immediate Cause (Final Pnysician 50 disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 9 Linknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ပ 1 🗌 Yes 2 X No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of De th Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident (Month, Day, Year) injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated pertifying Nurse Practioner: To the best of my modified the course at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) Date signed (Month, Day, Year) 29b. Signature nd address of person drw d

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Frances L. Marschall 28^{ay} Physician/ Month 20^{Yea}l 8:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 703 Whitehall Beach Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

March 24, Anne Arundel Annapolis Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 1 - M 2XX 577-16-2292 92 Director Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Maryland Anne Arundel Annapolis 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 703 Whitehall Beach Road 21409 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🛛 No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3XXWidowed 4 ☐ Divorced Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Beautician Beauty Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Richard Westlake Lease မ Verta Viola Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pam Masterson/daughter 703 Whitehall Beach Road Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State 6/6/2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory Baltimore, Maryland neral en e Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Month disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to for as a consequence of, attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Dav Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Plesidence} \) 6 \(\text{Other} \) Other (Specify) Certificate: To 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 UNatural 5 Pending 1 Tes 2 🔲 No Investigation Could not be Accident Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Newse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Chaconas 1509 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Examin		4a. Facility Name (if not institution, give stree				Location of Death		4c. County of [
Funeral		Anne Arundel Med: 5. Social Security Number 6. Sex	1Cal Center		Annap	OIIS If Under 24 Hrs.	8. Date of Birth		Arunde1 Birthplace (State or Foreign
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s 23a	Funeral	1612 Elkwood Ct.			21	409		USA	
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s after	ed by		1 TX Yes 2 □ No If Yes, Give Year or DatestW . W .]	I 1	☐ Yes 2X No	Specify:			Black
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should and h is ma		19a. Informant's Name/Relationship (Type, F		19b. Mailin	g Address (Street a	and Number or Rur	al Route Number,	City or Town, State	, Zip Code)
and 2 Health em 27 ther t		Nathaniel Martin 20a. Method of Disposition						s, Md.	
age 1 ant of nt: If it y or o		1 X Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)			stron (Name of hatory or other place 1 Park	6-3	Date 1 1	20c. Location - City Landove	
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee						ary, P.	
		Lavy S, Ree	··	1	922 For	est Dr.	Annapo	olis, Md	
-		23a. Part 1. Enter the disease, or complicati shock, or heart failure. List only one car	ons that caused the death. use on each line.	Do not ente	r the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
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l or Al after of Direc		4 ☐ Homicide determined 2	 Place of Injury - At hom building, etc. (Specify) 	e, farm, stre	et, factory, office		28f. Location (St. City or Town		Rural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying Physician (Check 2 Medical Examiner; 0	: To the best of my knowled	lge, death o	occured at the time.	date and place, a	nd due to the cau	se(s) and manner as	s stated.
the H thin 24 the Fi mplete	Me	only one) 3 Certifying Nurse Pra	on the basis of examination a actioner: To the best of my k	nowledge, o	leath occurred at the	time, date and pla	ce, and due to the	cause(s) and manne	
₽ ₹ ₽ 8		29b. Signature and title of certifier	1 = 111		29c. License	mall	2	9d. Date signed (M	onth, Day, Year)
		30. Name and address of person who comple	eted cause of death (Item 2)	3a) (Type, P	rint)	00/		0 1 0/1	2.0
H1+1	1	Robert T le	terson w	11)	rint) AA	MC	Ann	opelis 1	MD 21401
Stat Registra		31. Date filed (Month, Day, Year) 6 201	32. Registrar's Signatur	A. J.	backer			U	
3.00.0			1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Robert James McConnell 2011 4:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stagnes
5. Social Security lumber Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 20, 1935 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** Months 1**⊠**M 2□F Hours Days 109-26-4783 75 Yrs **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at MD Baltimore Baltimore Director 1 ☐Yes 2X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5605 Ashbourne Road 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1960. 1 XYes 2 No 1965 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2X No White ģ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Internal Auditor General Services Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: if Item 27 Is marked other t Jury or other traumatic event, In marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James F. McConnell Eleanor Ryan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: if item 27 is
any injury or other trau Cheryl Amirault/ Daughter-in-law 8022 Foxtail Lane Glen Burnie, MD 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State June 03, Metro Crematory, INC. Baltimore, MD 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CREMATION DIRECT 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiovascu lari disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) as been signed by the 2 should be detached 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an autopsy page certificate 3 No of Vital 1 ☐ Yes Hospital or Attending Physician; director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 | Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident ours after death. 1 ☐ Yes 2 ☐ No 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave Baltimore naven Mason 31. Date filed (Month, Day, Year) State JUN 0 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marta Lucille Agnes Morris 2071 0555 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritis Medical Center Washington Hagerstown If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Oct. IO Min. 577-36-2340 Virginia Director 83 1927 Usual Residence of Decedent 28a-f show 10a. State filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. Frederick Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6568 Buttonwood Court 21703 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc.
White Armed Forces? ģ 1 Never Married 2 Married Maryland 21215-0036 i ⊟ res 21 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 Public School System Administrative Aide Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Webster John Garrison Ethel Henry McAllister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Brewbaker / Daughter 5701 Mill Run Place, Frederick, Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Salem Cemetery 6/3/2011 Brookeville, Md. 4 Donation 5 Other (Specify) Sign of Funeral Service Doense 22 Name and Address of Facility
Muriel H. Barber Funeral Home M-00470 0. Box 5038. Laytonsville 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death hock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph, irian disease or condition resulting in death) Medical Due to (or a consequence of Examiner W Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed after death. Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav Year signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown been a 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? After this certificate 2 🗌 No Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Lirector A

completed filled in by the f Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

10

egistrar's Signatur

1126 Day Court

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month David F. Miller 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2110 Alice Avenue Prince George's Oxon Hill 5. Social Security Numbe 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** New Jersey 1 X M 2 - F Hours 097117195 209-42-4681 59 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10c. City. Town or Location 10d. Inside City Limits Directo Carbon 1 Yes XX No Pennsylvania Palmerton Palmerton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 650 Lime Street 18071 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 X Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) LTK Engineering Serv. Elementary/Seconday (0-12) 12 years College (1-4 or 5+) Quality Assurance Inspector Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic er Francis Miller Sadie Mayberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Miller / Wife 650 Lime Street Palmerton, PA 18071 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 🗀 Cremation 3 🔀 Removal from State 06/09/2011 4 Donation 5 Other (Specify) Musconetcong Valley Cem. Hampton, New Jersey f Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA Signat an 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications Approximate Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final Physician Therose disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 4 ☐ Pregnant a 9 ☐ Unknown 1 L Yes 2 L 9 Dunknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig ; page 2 should b 2 No 3 Probably 4 Unknown Completed 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this Director: After this in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours af

To the Funeral Di

completed filled in Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

CR 20

State Registrar 30. Name and address of person who completed

Salvado Suveft

31. Date filed (Month, Day, Year)

2011

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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 Phys M Exa To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760

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			For State	State of M	aryland				Mental Hy	giene		
			Registrar 1. Decedent's Name (First, Middle, La	est)		Cer	tificate of L	Jeath	2. Date of De	Reg. No.	2011	3. Time of Death
artic.	Physicia Medic	al	EUNICE A 4a. Facility Name (if not institution, giv		bline	aux	I 01 T		Month	Day	2011	0720P M
	Funeral Director	ier	5. Social Security Number 6.5 439-16-5212	1th Case 7. Ago		t birthday) Yrs.	Ab. City, Town, or House 1 Year Months Days	If Under 24 Hrs Hours Min.		th W	County of Deat 9. Birt Cou	
	and show d at	힏	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Maryl 28a-f ootifie	Director	MD Washi	ngton		Н	agersto	wn				1 X Yes 2 ☐ No
	with the is 23a or	Funeral D	10e. Street and Number 333 Mill St.				10f. Zip Code 21	740		10g. Citi	zen of What Co	untry? SA
21215-0036	e filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show event, th. M-dical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2X If Yes, Give Year or Dates.			Vas Decedent of H f Yes, specify Cuba		pecify Yes or No- o Rican, etc.)	- 1	14. Race - Amer Black, White Specify: Wh:	e, etc.
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land	be filed ental Hy rked oth ic event	To Be	17. Father's Name (First, Middle, Last) John A. Allen			-			me <i>(First, Middle,</i>		Sumame)	
Maryland	ge 1 and 2 should be file It of Health and Mental I It item 27 is marked of or other traumatic eve	•	19a. Informant's Name/Relationship (Linda Summers		:)	19b. Mailin	g Address (Street a	and Number or Ru nia Ave	ral Route Numbe	er, City or erst	Town, State, Zip	MD 21740
Baltimore,	permit. Page 1 and 1 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1	Removal from State	20b. Pla	ace of Dispo metery, cren thsb	sition (Name of natory or other place urg Cre	matory6	Date /3/201	20c. Lo 1 S m j	cation - City or	Town, State
Balt	permit. Departi Import any inj		21. Siglature : Funeral Service Licer	sec		Ď P	onandada OB 18,	of Thomp Middlet	son Fu	nera D 21	1 Home 1769	2
	Physician/ Medical		23. Part 1. Inter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each line a. Dishot			r the mode of dyin					Approximate Interval Between Onset and Death
	Examiner	_	Sequentially list conditions,	Due to (or as a	conseque	ence of):						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a	conseque	ence of):	iem Ste	200,5				
00	e be executed ysician and ne burial-transit	lical Ex	resulting in death) Last	Due to (or as a			Jan A	ccided				
68760	irtificat ling ph e as th	/Mec	IF FEMALE:	23c. If yes, outcome								
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Division of Vital Records, P.O.	quires that i en signed b ould be deta		Part II. Other significant conditions of Advanced Vasc	contributing to death be								the cause of death?
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lital	sician certifi irector	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Othe	ace of Death (Che				
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	the Hospi nin 24 hou the Funer npleted fil	Medical	(Check 2 ☐ Medical Examonly one) 3 ☐ Certifying Nu	rsician: To the best of exiner: On the basis of exise Practioner: To the l	kamination :	and/or invest	igation, in my opinio	n, death occurred	at the time, date a	and place,	and due to the c	ause(s) and manner stated.
	7 with		29b. Signature and title of certifier	de-Blue	Den	CRNP	29c. License	5360		29d. Date	signed (Month	, Day, Year)
	2		30. Name and address of person who Barbara Nade,	completed cause of de	eath (Item 2	23a) (Type, P		mills	Street	, Ha	cersta	am, MD
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	ire A	backer					21740
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		•	1 - For State Registrar	State of Maryl	and / Depa	artment	of Health ar		ntal Hygid	_	1 19818
	•		Decedent's Name (First, Middle, Last)			timodic	01 20411	2.	Date of Death	J. 140.	3. Time of Death
P	Physici		George Joseph	Mendonca					Month June 1	Day 2011	9:00P M
4	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, T	Town, or Location of		June 1	4c. County of	
			8400 Dasher Court	t		Ga	ithersbur	g		Mont	gomery
	Funeral		5. Social Security Number 6. Sex	, _	yrs. last birthday)	If Under	1 Year If Under 24 Days Hours	4 Hrs. 8. Min.	Date of Birth (Month, Day,)	rear)	Birthplace (State or Foreign Country)
Н	Director			M 2□ F 8.	5 Yrs.	Nichard	Bayo House	Jı	ine 16	1925	New York
	and		Usual Residence of Decedent 10a. State 10b. County	10c.	. City, Town or Lo	cation					10d. Inside City Limits
	Maryl 1 sho	ŗo	Md. Montgor	nerv	Gaith	ersbu	re				1 ☐ Yes 2 XNo
	r 28e	rec	10e. Street and Number			10f. Zip			10	g. Citizen of Wh	at Country?
	within 72 hours after death with the Maryland ene. than "neturel", or Itams 23a or 28e-1 show Ita M.clical Evanifar must be notified at	Funeral Director	8400 Dasher Court				20882			United	States
	ams arms	ner	11. Marital Status	2. Was Decedent Ever i Armed Forces?	in U.S. 13.	Was Decede	ent of Hispanic Origi rly Cuban, Mexican,	in? (Specify	Yes or No-		American fndian, White, etc.
98	or It	y Fu	1 ☐ Never Married 2 ☑ Married	1 M Yes 2 □ No τ If Yes, Give	TITT	1 ☐ Yes 2			,	Specify:	White
Ö	hour:	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a Dooo	dentie Lieusi	I Occupation			6b. Kind of Busi	
7	in 72 n "na	olete	(Specify only highest grade	completed)	(Give	kind of world DO NOT use	k done during most o e retired)	of working	"	bb. Kind of busi	nessmoustry
212	d with giene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			fficer			Federal	Government
פָּי	e filed al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother	's Name <i>(Fi</i>	rst, Middle, Ma	aiden Sumame)	
<u>la</u>	Menta	70	Anthony Mendonca	a.			Phi	ilomer	na Cor	reia	
Maryland 21215-0036	2 shc and ls m		19a. Informant's Name/Relationship (Typ			-	(Street and Number				
	1 and sealth sm 27 shar t		Anna Gloria Mendor				ner Court	, Galt	-		ity or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28e-1 show appring to other treumatic avent, It's Madical Examinating the rotified at once.		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Re	BINOVALITORI STATE	b. Place of Dispo cemetery, crea				-		
Ħ	artmer artmer ortant injury		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signify e of Furleral Service Lice e		Gate of			6/7/1			Spring, Md.
Ba	Depa Impo eny ir		Val Color	1/_	0470	Murie.	Address of Facility L. Barbe Box 5038	er Fur	neral H	ome	20882
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on			ter the mode	of dying, such as ca	ardiac or re	spiratory arres	it,	Approximate Interval Between
	Physician		I mediate Cause (Final disease or condition				ne colon,				Onset and Death 2.5 years
	/Medical		resulting in death)	Due to (or as a con		O	,		, , , , , , , , , , , , , , , , , , , ,		2.5 years
В	Examiner		Sequentially list conditions, b.								
	ed isit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Undergraphy Cause (Disease or injury	Due to (or as a con	sequence of):						
•	xecut and al-trar	Examiner	that initiated events c. resulting in death) Last	Due to (or as a con	sequence of):						
760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	calE	4								
68											
Вох	h cer endin	N/N	23b. was decedent pregnant	Bc. If yes, outcome of pre		Ectopic pre	ananev.			23d. Date	
о. Ш	e deal	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time		Other (spe				Monti	h Day Year
<u>Ч</u>	d by t	by Physician/Med	9 ☐ Unknown Part II. Other significant conditions confi		and the second		in Bodi		22a Did toba	ann una anntrib	oute to the cause of death?
	se ug		Part II. Other significant conditions com	tributing to obatti but not	resulting in the u	noerlying ca	iuse given in Part I.		1 ☐ Yes	/	□ Probably 4 □Unknown
Vital Records,	w requir been s should	Completed			-			-		- 1	
Re	The lav	du							24a. Was an autopsy perform	pri	ere autopsy findings available or to completion of cause of ath?
ta		e Cc	25. Was case referred to medical				OC Place	of Dooth (C	1 ☐ Yes 2 li heck only one]Yes 2□No
	9 S =	0 8	examiner?	ospital:	2 ☐ ER/Outpatier	nt 3 DO	Othor		/	ce 6 Other	(Specify)
0	r Attending Physer death. Iractor: After this by the funeral di	T :uc	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea.	r) 28b. Time o	f 28	to, Injury at Work?			v injury occurred	
<u> </u>	Attending or death. actor: After by the fune	satic	2 Accident investigation	, , ,	,,=.,	М	1 ☐ Yes 2 ☐ No	o			
Division of	or Attencatter death Diractor: in by the	Certification	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str ecify)	reet, factory.	office	28f.	Location (Stre City or Town,	et and Number State)	or Rural Route Number,
	Hospitel		29a. Certifier 1 1 Certifying Physi	ician: To the best of my	knowledge deet	b	Adha siwa data and	lalasa and	due to the co	(-)	
	e Hospitel 24 hours a 8 Funaral I	Medical	(Check only 2 Medical Examin	er: On the basis of exan and manner stated.	nination and/or in	vestigation,	in my opinion, death	n occurred a	it the time, dat	e and place, an	d due to the cause(s)
	To the Hospitel or within 24 hours after To the Funaral Discompletely filled in	Me	29b. Signature and title of certifier			29c.	License number		29	d. Date signed ((Month, Day, Year)
)			Robert tick u	4			D 34740			June 2	2, 2011
(0+1		30. Name and address of person who cor	mpleted cause of death ((Item 23a) (Type,	Print)			1		
	2		Robert Fields, M.D			#	Dr., #200	0, 01r	ney, Md	. 2083	32
	Sta	te ar	31. Date filed (Month, Day, Year)	32. egistrar's S	ignature.	arke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Physician/ Month Dav Reginald Ellsworth Nutwell June 2011 10:53 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5752 Nutwell Sudley Road Anne Arundel Deale Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 X M 2 □ F 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth Days Months Min 04-27-1926 Mary Land Director 213-28-1762 85 Yrs. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 5752 Nutwell Sudley Road 20751 USA of Health and Mental Hygiene.
item 27 is marked other than "natural", or items
other traumatic event, the M-di-al Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced 1945 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Constable MD District Court Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be ... Department of Health and Mental. Important: If item 27 is morany injury or other. ည Marion Fennimore Childs Nutwell Edna Florence Sherbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vera Anderson Nutwell. Spouse 5752 Nutwell Sudley Road, Deale, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) James' Parish 06-10-2011 | Lothian, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. Willian 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 1 Yes 2 No 9 Unknown P.O. s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? the Hospital or Attending Physician; The law requires Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? Yes 2 N death? certificate 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one examiner? 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier n who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registra s Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ 10:40 AM Minnie May Newlin MINE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
July 20.1926 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🗶 F Hours Pennsylvania 201-18-1966 Director 84 July Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location the Maryland Director Washington Hagerstown 1 Yes 2 X No Marvland ō 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? "natural", or items 23a or Funeral within 72 hours after death with 9136 Cool Hollow Drive 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry than Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. should be filed with n and Mental Hygien is marked other th Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fetterhoff Tra Mary Jane Eichel traumatic t. Page 1 and 2 should by timent of Health and Mertant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9136 Cool Hollow Drive, Hagerstown, Md. 21740 Deborah A. Price Daughter Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Rose Hill Cemetery 06-08-11 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland Signature of Funeral Service License ²²AMnorew^{Ad}Cess Colliman Funeral Home, Inc. 40 East Antietam Street. Hagerstown 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Opeet and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and that initiated events Due to (or as a resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Day Month Year Pregnant at time of death 1 Yes 2 Unknown the detached 9 Unknown cate has been signed by to page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autonsy performed? 1 ☐ Yes 2 ★No Yes 2 funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 \square Yes Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No မ ER/Outpatient 3 DOA 1 Impatient 2 🗆 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: 28d. Describe how injury occurred 1 Aratural iniury 5 Pending 24 hours after death. Funeral irrector: A 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗖 within 2 the only one 29b. Signature and title of 29c. License number D 35 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OPAL CT. HAGGRSTOWN MAZITY JW - 3 State Registrar

11-03902 Terry Nelson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

erry Nelson	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2011	1982
Physician/ ledical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	Time of Death
ieuicai Exammei	Terry Edward Nelson May 25, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	01201113
	306 9th Avenue Brunswick Frederick	
Funeral Director	5. Social Security Number 215-64-0970 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplication of the property of the prope	Brunswick MD
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10	d. Inside City Limits
E	MD Frederick Brunswick 1	X Yes 2 No
the Maryland or 28a-f show iffed at once. Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 306 9th Avenue 21716 USA	?
with the us 23a o		Indian, Black,
or death with		te
ours after	or Dates:	
by MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4 or 5+) 12 during most of working life. DO NOT use retired) North Ameri Housing, Pt	
5-00. led with Hygiene other t		
21215-003 uld be filed withi Mental Hygiene, marked other it e event, the Med		
MD 21215-0036 a 2 should be filed within 7 b and Mental Hygiene. a 77 is marked other than numatic event, the Medica To Be Comple	Gary W. Nelson, Brother 23 Petersville Road, Brunswick, MD 2171	
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumatii	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 20b. Place of Disposition (Name of ceme	vn, State
Baltimore, oermit. Pages I au Destruent de Belle Department of Helle Important: If ite injury or other tr	4 Donation 57 Other Specify: Hagerstown Crematory 5/31/2011 Hagerstown,	MD
Bal Permi Depar Impo injur	John T. Williams Funeral Home	21716
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	Death
-	Sequentially list conditions, b. b. b. if any, leading to immediate Due to (or as a consequence of):	
ted Insit Examiner	(Disease or injury that initiated curve (Indext) Last Due to (or as a consequence of):	
and and Transit	events resulting in death) Last Due to (or as a consequence or): d.	
oo, te be execut ysician and burial - tra ledical	UNPENDED AMENDED	
ox 6876 eath certificate attending phy for use as the rsician/M		Year
	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)	
ires that the d signed by the 1 be detached		
ds, P	Chronic alcohol abuse 1 ✓ Yes 2 No 3 Probabl	y 4 Unknown sy findings available
of Vital Records, ig Physician: The law requires ther this certificate has been signeral director, page 2 should be 7: To Be Completed	autopsy prior to comperformed? death?	pletion of cause of
tal Relician: The certificate rector, page	1 Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one)	2 No
F Vita Physicia rr this co	D1 ✓ Yes2 No	ene
Division of Vital F Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifi- tely filled in by the funeral director, al Certification: To Be C	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Investigation or Town, State)	Route Number, City
E Hospita 124 hours Funcral letely fille		
To the Ho within 24 To the Fr completel	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ca	
≥	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, O.C.M.E. May 25, 2011	∪ay, Year)
6	30. Name and address of person who completed cause of death (Item 23a)	
	Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
State Registrar		

11-03843 LINK LINK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

NK UNK		Stat	e of Marylan	d / Depa		Health and	d Mental	Hygiene	20	111 1000
Dhygiai	on/	Registrar 1. Decedent's Name (First, Middle,L	ast)	Cer	tificate of	Death ————		R 2. Date of Dea	eg. No.	3. Time of Death
Physici Medical Exami		David Spencer N	eale					Month May 22, 2	Day Year 011	1956 hrs
		4a. Facility Name (if not institution, of 2506 Lemon Tree Lane	give street and numb	er)	41	. City, Town, or Largo	Location of De	ath	4c. County of Prince G	
Funeral		Social Security Number 6.	Sex 7	Age (In yrs. la	ast birthday)	If Under 1 Year			th(MM/DD/YYYY)	Birthplace (State or Foreign
Director			X M 2 F	36	Yrs.	Months Days	Hours I	vin. 03/20	1/1975	Country) DC
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locatio	n				10d. Inside City Limits
	or	MD Prince	Georges		Springd	ale _		_		1 X Yes 2 No
5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once.	Director	10e. Street and Number	- 1			10f. Zip Code		1	0g. Citizen of Wha	at Country? JSA
with the 18 23a c		2506 Lemon Tre	12. Was Decede	ent Ever in U.	S. 13. Was		panic Origin?	Specify Yes or No		- American Indian, Black,
death y	Funeral	1 X Never Married 2 Marri	1 Yes	es? 2 X No		s, specify Cuban		erto Rican, etc.)	White,	
rs after ural",	ģ	Widowed 4 Divorce Decedent's Education (Specify)	ed If Yes, Give Year or Dates:	ompleted)		Yes 2 X No s Usual Occupat		of work done	Specify: 16b, Kind of Bus	Black
72 hou a "nat	eted	Elementary/Secondary (0-12)	College (1-4			st of working life.				
15-0036 filed within 72 hours at Hygiene. ed other than "natural t, the Medical Examin	Completed	75	5+		Z.	tudent			Educati	
- = ∃ B +	Be Co	17. Father's Name (First, Middle, La Daniel Spencer	•					ame (First, Middle, I cia A · Ar		
MD 2121 (2 should be fill h and Mental F 27 is marked imatic event, 1	2	19a. Informant's Name/Relationship	(Type, Print)			,		or Rural Route Nur		, State, Zip Code)
- P =		Daniel S. Neale 20a. Method of Disposition	/ lauler		Place of Dispositi	ion (Name of cer		Date		City or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		1 Burial 2 X Cremation 4 Denation 5 Other Speci			rematory or other Sapeake		ory 06	104/2011	Beltsvi	ille, MD
laltir amit. I epartm aporta jury on		21. Si mature of Funeral Service Lice	erisce		22. Na	me and Address			d Funera	al Services
Physician	Y 35	23a. Part I. Enter the disease, or con	mplications that caus	ed the death.	Do not enter the	L500 A	Llentow	n Rd - 1	Camp Spri	ings - MD 20748
/Medical	8 8	failure. List only one cause on	each line. a. Morphine Into			, , ,		,	,	Between Onset and Death
xaminer		or condition resulting in death)	Due to (or as a co		r):					
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	nsequence of	r):					
	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):					
e executed ician and irial - transit	dical E	UNPENDED	d							
60, ate be e hysicia e burial	Medi	IF FEMALE:	23c. If yes, outo	come of pregr	nancy				23d. Date of c	delivery
ceath certificate be attending physic for use as the bun	ᇛ	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Feta	I death 3 [Ectopic pre	gnancy	Month	Day Year
Box 68760, e death certificate b the attending physical for use as the but	Physicia	1 Yes 2 No 9 Unkno			atn 5 Othe	er (Specify)			<u> </u>	
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	by P	Part ii. Other significant condition	contributing to de	ath but not re	sulting in the un	derlying cause g	iven in Part I.	23e. Did to		oute to the cause of death? Probably 4 Unknown
ords, I								24a. Was	an 24b. W	/ere autopsy findings available
Recor The law I cate has b	Completed							_ autop perfo 1 ✓ Yes	rmed? de	nor to completion of cause of eath? Yes 2 No
Vital Rec ysician: The his certificate director, page	Ф	25. Was case referred to medical					of Death (Che		2 110 1	• 100 I II
Physici r this c	70 B	examiner? 1 ✓ Yes 2 No			ER/Outpatient			rsing Home 5		*
ion of tending Pheath.	cation:	27. Manner of Death 1 Natural 5 Pending	28a. Date of I FOUND:	y,Year)	28b. Time of Inj		y at Work? ′es 2 ✔ No	Unknown	how injury occurre	ď
Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been seen is the funeral director, page 2 should	ificat	2 Accident Investig 3 Suicide 6 ✓ Could n	28e Place of		1954 hrs me, farm, street,	factory, office b	uilding, etc.	28f. Location (r or Rural Route Number, City
Dj sepital hours a meral I y filled	Certific	4 Homicide determine	(0)0000))					2506 Lemon	Tree Lane, Larg	
Division To the Hoopital or Attent within 24 hours after death To the Funeral Director:	Medical	(Check only one) 2 Medicai Examir	ician: To the best of er:On the basis of e	xamination ar	ge, death occurre nd/or investigatio	ed at the time, da n, in my opinion	te and place, a , death occurre	and due to the caused at the time, date	se(s) and manner a and place, and du	as stated. ie to the cause(s)
10 10 00 00 00 00 00 00 00 00 00 00 00 0	Ψe	29b Signature and title of certifier	and manner state)		29c. License		_	29d. Date signe	d (Month, Day, Year)
		Matulbro	rica -	alla.	kus	O.C.I	И.Е . 		May 23, 201	11
R 5		 Name and address of person wh Patricia Aronica-Pollak N 	•			00 W. Baltin	nore Street	, Baltimore, M	D 21223	
S	ate	31. Date filed (Month, Day, Year)		trar's Signatu						
Regis	121	THE CAUSE /4	MARKET OF.							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 06 2011 Scott E. O'Neal ďľ 7:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number If Under 1 Year | If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F Country) 512-36-3072 119264 1917 Director 93 TA Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD <u>Calvert</u> Solomons 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 11740 Asbury Circle. United States Apt.1508 20688 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify. "natural", Completed 3 X Widowed 4 Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) t should be filed within 72 and Mental Hygiene. United States Elementary/Seconday (0-12) College (1-4 or 5+) Career Military Air Force æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward O'Neal Rose Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick O'Neal / Son 3073 Eutaw Forest Drive, Waldorf, MD 20603 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington National Cem. 07/20/2011 Arlington, VA Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral Service Licenses Amanda M. Ergler mois 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause val Between Immediate Cause (Final Physician/ OSEDSI disease or condition resulting in death) Medical Examiner a Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the a detached f Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by has been sig je 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha autopsy performed? Yes 2 No 2 No Be 25. Was case referred to medica funeral director 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 X No 우 1 Inpatient 2 ER/Outpatient 3 DOA this (4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural (Month, Day, Year) within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year) nd address of p death (Item 23a) (Type, Print) rson who completed cause dew 15

DHMH 17 Rev 7/2009

Registrar

Noma S / Date filed (Month, Day,

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Dav 2011 Sandra J. Pizzo May 23. 9:55P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Kline Hospice House Mount Airy Frederick 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) 1 □ M 2X F Months Days Hours 238-06-1235 Director 56 April 23. 1955 Colorado Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinations. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Frederick Monrovia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4590 Kemptown Court Funeral 21770 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2X No þ Specify. White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 years Consultant Computer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Gordon Howard La Tourette Joyce A. Wood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J. Pizzo III - Husband 4590 Kemptown Court, Monrovia, Maryland 21770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematorium 5/24/11 | Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service icenses Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence ancer disease or condition resulting in death) /Medical Examiner ecus tastati Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours are death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the humal themost Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ZNo Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 🖾 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

5

1502 South Main Street, 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Griffin M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D55104

May 24, 2011

Mount Airy, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Ma					ental Hyg	iene			
		_	State Registrar	C	Certificate	of De	eath		leg. No. 2		19825	
	Physicia Medic		Decedent's Name (First, Middle, Last) MARY SUE POTT	ER				2. Date of Dea Month May	25° 20	Year 1	3. Time of Death 5:15 P _M	
	Examin		4a. Facility Name (if not institution, give street and number)				ocation of Death		4c. County			
	<u> </u>		Glade Valley Nursing & Reha 5. Social Security Number 6. Sex 7. Age				ILLE f Under 24 Hrs.	8. Date of Birth	Fred		lace (State or Foreign	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 XF 7. Age	(In yrs. last birthda 84 Yrs	Months		Hours Min.	Dec. Bate of Birth	Year 926	Indi		
	and show	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	r Location					1	0d. Inside City Limits	
	Maryla 18a-f	Director	Maryland Frederick	Thurmon	ıt						1 Yes 2 X No	
	ith the I 3a or 2 t be no		10e. Street and Number 8527 Hunt Club Road		10f. Zip 0	Code 1788			_	of What Country?		
	leath w	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Deceder	nt of Hisp	anic Origin? (Spec Mexican, Puerto F			e - Americ		
50	after d al", or i Examin	ρ	1 Never Married 2 Married 1 Yes, Give 1 Year or Dates.	No	1 Yes 2			nour, oro.,	Specify:	k, White, 6 Whi		
5	hours natur dical B	olete	15. Decedent's Education (Specify only highest grade completed)		ecedent's Usual		on ing most of workin	ng I	16b. Kind of B	usiness Inc	lustry	
9500-61212	ithin 72 ene. • than " the Me	Completed	Elementary/Seconday (0-12) College (1-4 or 5-	116	e. DO NOT use n		ing most of workin	79	N	ursin	ıg	
מ	filed wall Hygist of other	Be	17. Father's Name (First, Middle, Last)	1			8. Mother's Name		Maiden Surname	r)		
ryiand	d Ment marker matic	입	Carroll Wallace Kent 19a. Informant's Name/Relationship (Type, Print)	10h N	Apiling Address (Fern Han		City or Town S	tate Zin (ande)	
, Mar	nd 2 sho salth an n 27 is er trau		Sarah Bartgis / Sister	169	1 Shook	stow	n Road,	Frederi	ck, MD	21702		
saltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Me Tical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		cation - City or Town, State hsburg, Maryland							
Dall	permit. Departr Import any inji		21. Signature of Funeral Service Licerson				ATLEY & S					
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not	enter the mode	of dying,	such as cardiac or	r respiratory arre	est,		Approximate Interval Between	
+	hysician/ Medical	0 1	Immediate Cause (Final disease or condition resulting in death)	mie af	potr	ud	twe pr	elmone	un dea	ane	Onset and Death	
	_xaminer		Due to (or as a consequence of): Sequentially list conditions, b.									
	sit	Examiner	if any, teating to immediate cause. Enter Underlying Cause (Disease or linjury	tonesquente ut;								
	ate be executed ohysician and the burial-transit	Еха	that initiated events c.	consequence of):	<u> </u>							
20	ate be o	dical	d									
200	certifica ending p use as t	an/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth		3 ☐ Ectopic pr	едпапсу			23d. Da	te of delive	ery	
. Box	the death by the atte ached for	Physician/Me	in the past 12 months? 1 Yes 2 No 4 Pregnant at 9 Unknown		5 Other (spe				Mo	nth	Day Year	
is, r.o	uires that n signed k uld be det	Completed by P	Part II. Other significant conditions contributing to death be	ut not resulting in t	the underlying ca	ause giver	in Part I.	23e. Did to	1/		e cause of death?	
Vital Records,	law req has bee e 2 shor	nplet	Hypertension		0			24a. Was a autop	sv		osy findings available mpletion of cause of	
<u> </u>	n: The ficate nr, pag	e Co	25. Was case referred to medical			ac Diag	e of Death (Check	1 🗆 Yes		I ☐ Yes	2 🗆 No	
ıta	sicial s certi	To Be	examiner? Hospital:	ent 2 ER/Outp	atient 3 \ DO	Other	Λ		ence 6 🗆 Oth	er (Specify)	
0	ing Phy		27. Manner of D≠th 28a. Date of injur Natural 5 □ Pending (Month, Day	ry 28b. Tim	ne of 28	c. Injury a work?	2		ow injury occurr			
DIVISION OT	or Attend after death Director: A in by the f	Certificate:	2 Accident Investigation	ıry - At home, farm	M , street, factory,		es 2 No	28f. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Number,	
a	In the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical (29a. Certifier Certifying Physician: To the best of (Check Medical Examiner: On the basis of even only one) 3 Certifying Nurse Practioner: To the	kamination and/or in	nvestigation, in m	y opinion,	death occurred at	the time, date as	nd place, and du	e to the car	use(s) and manner stated	
	No the within To the compl-	Σ	only one) 3 L Certifying Nurse Practioner: To the 29b. Signature and title of certifier	and the street of the street o		License n			29d. Date signer			
			30. Narge and address of person who completed cause of de	State (Itom 222) (Time	San L)3	518	3 1	lag o	16,	2011	
			Ali J. A Godskitel	300	West	190	th Street	+ Fre	deri	E,	120	
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registra	ar's Signature	Sarke	1	•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 11:22 Willard Dale Parrish 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis College View Center Frederick Frederick Birthplace (State or Foreign Country)
 Va 5. Social Security Number If Under 1 Year If Linder 24 Hrs. 6. Sex 8. Date of Birth **Funeral** Hours 1 🕅 M 2 🗆 F Director 79 233-46-6105 show 10c. City, Town or Location 10a. State 10d. Inside City Limits at Director r 28a-f sh notified a 1√2 Yes 2 □ No MD Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ms 23a or must be r Funeral 620 Merridale Blvd. 21771 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 XI

If Yes, Give
Year or Dates. Black, White, etc. 5 ģ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 Yes 2 No Specify: White "natural" Completed 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) U.S. Defense College (1-4 or 5+) Elementary/Seconday (0-12) <u>Stationary Engineer</u> Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental item 27 is marked nd Mental marked o ပ္ Willard D. Parrish Myrtle E. Pridemore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 620 Merridale Blvd., Mt. Airy, MD 21771 Carol Parrish / wife injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory 6/12/2011 Smithsburg, MD 22. Name and Address of Facility Keeney & Basford Funeral Home Signature of Funeral Service Licensee Wh. MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Poset and Death Physician/ EMENET (A disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of this certificate has autopsy performed? death? 2 VZ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 🗌 No 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated litle of certifie 29d. Date signed (Month, Day, Year) 0006 2223 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PLAYECY BOLANUM, (767) DEVE, PLENEUCEMY 21702. State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State
Registra Amend #5. Per Informant PCO6-14-11cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mont 1930 Arthur James Paul, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince Georges Prince Georges Hospital Center Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 1953 9. Birthplace (State or Foreign Social Security N 7. Age (In yrs. last birthday) **Funeral** Months 58 Washington, D.C. 578-70-335 Director January Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11801 Wimbleton Court 20774 United States "natural", or items edical Examiner mu within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced Year or Dates marked other than "natur matic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Agent Insurance Company vears other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Bertha Pau1 Arthur James Stringfellow 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 11801 Wimbleton Court; Upper Marlboro, Maryland 20774 Shawanga Rene McCoy Paul 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June $\overset{\text{Date}}{\mathbf{6}}$, 2011 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Suitland, Maryland Lipcoln Memorial Cemetery 21. In nature of Juneral Service Lic 22. Name and Address of Facility R. N. Horton Company Morticians, Hnc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiag or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** chaleste Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events the burial-transi Due to (or as a consequence of): resulting in death) Last iding physiciar Physician/Medical certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna5 ☐ Other (specify) in the past 12 months? Month Day Year signed by the a d be detached f Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 ☐ Yes 2 📈 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Other: မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Acciden☐ Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician To the best of m 29a. Certifier death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: (Check basis of ex d/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL 10 3001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Rudloff Delano Franklin Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany WMHS-RMC Cumberland If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Funeral North, Day Yea Nov 15. Country) 1 🖳 M 2 🗆 F OH Director 302-28-8435 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State should be filed within 72 hours after death with the Maryland Director or 28a-f sh notified a Cumberland MD Allegany 1 □X/es 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō ms 23a or must be r Funeral 21502 USA 157 N. Mechanic Street items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. WW II Specify "natural", 3 XWidowed 4 Divorced white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Med once. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Chef Culinary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margaret Driscoll Karl J. Rudloff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 157 N. Mechanic Street Cumberland 19a. Informant's Name/Relationship (Type, Print) MD 21502 Anna Palmer daughte 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Restlawn Memorial Gardens 1 X Burial 2 Cremation ☐ Removal from State 6/14/2011 MD LaVale 4 Donation 5 Other (Sg ecify) Sinnature of Fu al Service 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Septic Shock Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ora and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical death certificate be IF FEMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown 9 I Inknown Division of Vital Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an , page 2 has autopsy death? performed Hospital or Attending Physician: The certificate 1 Yes 2 No Yes 2 💢 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Be 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2**/X**(No မ 1💢 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending To the Hospital or Attendin, within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLCUPROOK RD. CLUMBERLAND, MD 21502 Wi JAN ENKE 31. Date filed (Month, Day, Year) JUN 2 1 2011

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** Lawrence McCormick Robinson une 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CambRIDGE DOR ChestER Hospital DOPCHESTER General If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Oct. 5, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 x M 2 □ F 91 Oct. 220-10-6024 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State MD Dorchester Funeral Director Cambridge 1K Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1206 Race Street 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Bace - American Indian 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 🙀 No Specify: WWII Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) salesman vending company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ira Edgar Robinson Lula Bramble ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Grace Robinson permit. Pages 1 a. Department of Hear. Important: If item 27 any injury or other rone. wife 1206 Race Street, Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem 6/6/11 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licenses 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Se **Physician** PSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neumania Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Lailune Jultion Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4 Pregnant at time of death 5 Other (specify) 9 Duknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760,

item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Prodical Examinating must be notified at

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29a. Certifier

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Saltimore, Maryland 21215-0036

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or items

e Hospital or Attending Physician: The law requires that the death certificate be executed

n 24 hours after death e Funeral Director:

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST CAMBRIDGE 503 NOMAN 31. Date filed (Month, Day, Registrar's Signature State

29d. Date signed (Month, Day, Year)

11-04242 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Martha Maria Repka State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month Marta Maria Repka 2055 hrs **Medical Examiner** June 5, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hagerstown Washington 283 Sunbrook Lane 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs, 8, Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex **Funeral** oreign Hungary Months Days Hours 197-34-8393 Director 82 Sep. 19,1928 1 M 2 F Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Maryland Washington County Hagerstown or 28a-f show Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked ofter than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be marified as access. or items 23a or 28a-f shomust be notified at once. Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 283 Sunbrook Lane 21742 U.S.A. Funeral 11, Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes White 3 X Widowed If Yes, Give Year 4 Divorced 1 Yes 2 No specify: Specify: 2 or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bank Teller Bank 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Erzibet Flettner Racs 8 Mihay Racs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12920 Caleb Ct. Mount Airy, MD 21771 Ann Marie Repka-daughter 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 6-8-2011 Smithsburg, MD Smithsburg Crematory 4 Donation 5 Other Specify. 22. Name and Address of Facility Douglas A. Flery Funeral Home 21. Stgnature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 Part I. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. Between Onset and /Medical Death a. Head injury complicating hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Year Day his certificate has been signed by the attending director, page 2 should be detached for use as past 12 months? Pregnant at time of death 5 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy performed? ✓ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes 28a. Date of Injury (Month Day,Year) Jun 5, 2011 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject fell 1 Natural 2045 hrs 1 Yes 2 ✔ No 5 Pending death. within 24 hours after death To the Funeral Director: 2 🗸 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 283 Sunbrook Lane , Hagerstown, MD determined (Specify) Townhouse / Rowhouse 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

2. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD

31. Date filed (Month CN YOF) 20

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

June 6, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month parbara 06 1105 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Iteal th care Hagerstown ashington lawor If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 🗆 M 2 🗓 F July 26, 1938 Maryland Months Days Hours Director 216-36-5379 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🗌 Yes 2 💢 No Maryland | Washington Fairplay 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Examiner must be Funeral 23a 7875 Fairplay Road 21733 USA items ; 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No Black, White, etc ö 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White If Yes, Give Specify: "natural", 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Home 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Ralph Sanford Marion Rita Schneider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra James C. Russell - Husband 7875 Fairplay Rd. Fairplay,MD 21733 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial—2 Cremation Donation 5 Other Cedar Lawn Mem. Park: 06-11-2011 Hagerstown, Maryland 21. Signature of Juner 1 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Advanced disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hypertenision that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death the g Unknown ed by t signed t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Suphaceal Reflux The law requires 1 Tes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown Completed Delusions, Paranoia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsv performe this certificate 1 Yes 2 No Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 A Residence 6 Other (Specify) 2 🔀 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R125360 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

egistrar's Signatu

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Mill Street, Hagerstown, MD 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amended #10b-10f perFH FCHD KS Certificate of Death 6/2/11 Decedent's Name (First, Middle, Last) 2. Date of Death Physician 25, 2011 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Yrs 213-91-5574 24 2011 Maryland May 1, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Mt. Airy 28a-f show Carroll Examiner must be notified at 4 700 2 NO Director Maryland Baltimore The Johns Hopkins Hospital 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 23a or 3097 Ballesteras Court 21771 North Wolfe Street USA Funeral . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or items 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 III If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🖥 No 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education (Specify onfy highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be James Reed Ryon M. Warfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3**097 Ba**llesteras Court, Mount Airy, MD 21771 Ryon M. Warfield, Mother Baltimore, 20b. Place of Disposition (Name of cemeter, crematory of other place)
Metropolitan
Crematorium, inc. 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State May 27,2011 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Molesworth-Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final hysician disease or condition resulting in death) Medical £xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Exami burial-transit certificate be executed a consequence of) 68760 Physician/Medical Box 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3

Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Inpatient 2 No 1 Tes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After or Attending 5 Pending investigation M 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c License number RES-000 30. Name and address of pe completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32, Registrar's Signature State D. park Registrar

DHMH 17 Rev 1/2001

11-04030 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jose Ramon Mejia Ramos State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Physician/ 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month Day May 29, 2011 1719 hrs **Medical Examiner** Jose Ramón Mejia Ramos 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24Hrs. B. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Min. oreignHonduras Country) Months Days Hours Director 965-85-0796 01/17/1980 31 1 X M Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 XX Yes 2 No or 28a-f show Maryland Frederick tant: If item 27 is marked other than "natural", or items 23a or 28a-f abov or other traumatic event, the Medical Examiner must be notified at once. Frederick Baltimore, MD 21215-0036

bernit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 靣 5511 Oberlin Place 21703 Honduras 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married Yes 2 X No 3 Widowed If Yes. Give Year 1 X Yes 2 No specify: Honduran Specify: White 4 Divorced 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 6 Carpenter Construction 17. Father's Name (First, Middle, Last) 1B.Mother's Name (First, Middle, Maiden Surname) Be Marta Ramos Ramon Jose Mejia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Medrano / Girlfriend 5511 Oberlin Place, Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ematory or other place) Restnaven June 4, 2011 Frederick, Maryland Donation 5 Other Specify Memorial Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. Catoctin Mountain Hwy. Frederick 💋 3ar. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line.

Immediate Cause Final disease a Multip Between Onset and /Medical a. Multiple Injuries xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760, tall or Attending Physician: The law requires that the death certificate be executed iclan/Medical UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown pleted page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Com this certificate Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other4 Nursing Home 5 Residence 6 Other: DOA 1 Yes 2 No 2Ba. Date of Injury After 27. Manner of Death 28b. Time of Injury 2Bc. Injury at Work? 28d. Describe how injury occurred May 29, 2011 Subject fell off horse and struck tree 1 Natural 1620 hrs Director: 5 Pending 1 Yes 2 ✔ No hours after death. 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 9600 Croom Road, Upper Marlboro, MD determined (Specify) Field To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 31, 2011 O.C.M.E.

Registrar

DHMH 17 Rev 1/2001

OCME 2006

State

aske

900 W. Baltimore Street, Baltimore, MD 21223

Assistant Medical Examiner

32. Régistrar's Signature

Grascas.

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD

31. Date filed (Month) Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 25 per me g917 7-7-11 yt
State of Maryland Department of Health and Mental Hygiene

			1 - State Registrar			Certificate of L	Death		Reg. No 🔘 🗍	1	100	21.
	Physicia	ın/	1. Decedent's Name (First, Middle					Date of Dea Month		Year	3. Time of	
	Medic	cal		onna Lee Hur	ley Rock			June June	4, 201		0610	Ам
	Examin	er	4a. Facility Name (if not institution	House Hospi	0.0		Location of Death	4c. County o		omery		
200	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birthp	ace (State or	Foreign
	Director	215-38-4529 1 M 2 F 72 Yrs. Months Days Hours Min. June 4,1939										ıd
	nd how at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										y Limits
	faryla Ba-f s tified	Director	Maryland Mont	gomery		Da	mascus				1 🗌 Yes	2 1 No
	the N a or 2	ä	10e. Street and Number	5		10f. Zip Code			10g. Citizen of What Country?			
	h with	Funeral	9114	Gue Road			20872			USA		
10	r deat or iten niner	by Fu	11. Marital Status1 ☐ Never Married 2 Mar	12. Was Decedent B Armed Forces? ried 1 \(\text{Yes} \) Yes 2		13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- America , White, e		
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		3 Widowed 4 Divorced	If You Give	NO	1 🗌 Yes 2 🗖 No	Specify:		Specify:	W	hite	
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Maryland	d be f Menta arked atic ev	မ	Edward L. Hur	ley	Annie F. Etzler H							
lan	shoul and I is ma		19a. Informant's Name/Relations	, , , ,	1	Mailing Address (Street a			*		ode)	
e, ~	and 2 Health em 27 ther tr		Bernard Joseph 20a. Method of Disposition	Rock, Husba		14 Gue Road	1	i			<u> </u>	
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once.		1 Burial 2 Cremation	/ - /	cemetery	Disposition (Name of crematory or other place	e)	Date	20c. Location - 0			
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Ř	Peri Peri Imp	- 5	anice	V. Janast	Z CBP	22. Name and Addres Moleswort 26401 Rid	h-Willian ge Road,	ns, P.A. Damascu	, Funera is, Maryl	il Ho Land	me 20872	
			23a. Part 1. Enter the disease, or shook, or heart failure. List of	complications that caused only one cause on each line	the death. Do no	ot enter the mode of dying	g, such as cardiac o	or respiratory arr	rest,		Approximate Interval Betv	
N	Phy ician/		Immediate Cause (Final disease or condition	a.	In	tracranial	Hemorrha	e		A	Onset and D	
-	Medical Examiner		resulting in death)	Due to (or as	a consequence of):		0	ONL	14000		
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):	CX	1 1 H	W.else	R		
	cuted nd ransit	kami	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): C. Due to (or as a consequence of): C. Due to (or as a consequence of):									
	cate be executed physician and the burial-transit											
8760	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Medical		d			CEVI					
9	aath certif attending for use a	157 1	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 Ectopic pregnanc	**		23d. Date	e of delive	ry	
Box	death he atte ed for	Physician/	in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown	4 Pregnant a		5 Other (specify)			Mon	th	Day Y	ear
P.O.	hat the dec ed by the c detached		Part II. Other significant condition	ons contributing to death b	out not resulting in	the underlying cause giv	ven in Part I.	23e. Did to	bacco use contrib	bute to the	e cause of de	eath?
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Δį	ital or urs aft ral Dir lled in			bullaling, etc	(Specify)			City or Tow	m, state)			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	(Check 2 Medical E	Physician: To the best of xaminer: On the basis of e	xamination and/or	investigation, in my opinio	on, death occurred at	the time, date a	nd place, and due	to the cau	se(s) and mar	ner stated.
	To the within To the compl	Σ	29b. Signature and title of certifier	Nurse Fractioner To the	SHIRE OF LINE MINORARE	29c. License			29d. Date signed			
			> Stur	Wills	ins	D	63195		June	e 5,	2011	
	15		30. Name and address of person	•		/pe, Print)						
	1 2 2 2 2 2		Dr. Steven D. 31. Date filed (Month, Day, Year)		430 Rock	ledge Drive	, Suite	70, Bet	thesda, 1	MD 20	0817	
	Stat Registra		MIN O 6	nner i we	ars signature.	parkel						

fax to ME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Month June Physician/ Larry Gene Rutherford 9:50 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 139 Limestone Rd. Washington Hancock Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 XM 2 □ F Hours 01/31/1935 Director 245-46-9409 76 Yrs Usual Residence of Deceden 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director injury or other traumatic event, the Medical Examiner must be notified 1X Yes 2 ☐ No MD Washington Hancock ō 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a 139 Limestone Road 21750 USA permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked others... 12. Was Decedent Ever in U.S. Armed Forces?
1 Ⅸ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify 3 X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Heavy Equipment Operator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Howard Rutherford Martha Irene Phipps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Turner/Daughter 135 Limestone Road Hancock, MD 21750 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Smithsburg Crematory 106/13/2011 Smithsburg, MD 21. Signature of Funeral Sen 22. Name and Address of Facility 141 West Main Street M00260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ nonsmall cell was cancel disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? diabetes mellitus 24a. Was an his certificate has bil director, page 2 sl autopsy performed 2 🗌 No 1 Yes Yes 2 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 ☐ No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0 5

State

only one)

29b. Signature and title of certifier

Date-filed (Month, Day, Year,

- Kuther - Sando, mo

32. Registrar's Signature

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia Kuther Sands, MD Hospice of Washington County, Hagerstown, Maryland
31. Detailed Month Day York

D47451

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per fh g916 6-23-11 vt and Mental Hygiene amend 5, per fh, g918 8-17-17-17 Tealth and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 0934 May Willie Reed

4a. Facility Name (if not institution, give street and number) Medical 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Bethesda Suburban Hospital 251LS4643734 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) 0 / 25 / 1917 -16 - 191793 Director Usual Residence of Decedent 28a-f shov 10a, State 10c. City, Town or Location 10d. Inside City Limits at Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sl any injury or other traumatic event, the Medical Examiner must be notified. Hyattsville Y Yes 2 No Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20782 4916 LaSalle Rd. #@5 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Private Industry Leather Craftsman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joshua Reed Mary Cora Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20018 1713 Otis St. NE Washington, DC Adria Reed/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Ft. Lincoln 1 XBurial 2 Cremation 3 Removal from State Brentwood, MD 6/4/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furnish I Service Licensee 22. Name and Address of Facility Latney's Funeral Home, cc0278 3831 Georgia Ave. NW Washington, DC 2001 23a. Part 1. Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORDNARY Physician/ ARTERY disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Yea Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **P**No မှ 1 ☐ Inpatient 2 ☑ ₹R/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Gartifying Nurse Frectioner: To the best of my knowledge; death oncurred at the time, date and place, and due to the revise(s) and manner as state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Saw, Unis 5126/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, 10110 Molecular Dr. Rockville, MD 20850 31. Date filed (Month, Day, Year)

Registrar

JUN 0 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Donna Lynn Schaeffer 2011 June 6, 7:00 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 6230 Ripley Road LaPlata Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sept. 6, 1963 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 DM 2 X F Months Min. Days Hours 220-80-5552 Director Yrs Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director must be notified Maryland Charles LaPLata 1 Yes 2 No 10e. Street and Numbe 9 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20646 6230 Ripley Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administrative Assistant Retirement Community Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) bef Sophia Godfrey Donald F. Schaeffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra-6230 Ripley Rd., LaPlata, Md. 20646 Donald F. Schaeffer Father 20b. Place of Disposition (Name of cemetery, crematory or other place) June 7 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Funeral Service Alexandria Virginia 21. Signature of Funeral 22. Name and Address of Facility
Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Bx Immediate Cause (Final Onset and Death ancel Physician/ -eas disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Gause (Disease or hinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buris Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕱 No Pregnant at time of death 5 Other (specify) Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performe certificate 2 🗌 No Yes 2 1 Tes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 1 Tes ျ 1 Inpatient 2 ER/Outpatient 3 DQA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred runeral Director, After ampleted filled in by the firm ∃√Ñatural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

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Backs

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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JUN 0 8 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ lenn 201 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death unty of Death Examiner edical yer, tus ente ageistour Social Security Numbe 7. Age (In yrs. last birthday) If Unde If Under 24 Hrs. 9. Birthplace 8. Date of Birth **Funeral** Maryland 220-70-9520 Months Hours Min. (Month, Day, Year) Director Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland | Washington Hagerstown 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral Apt. 7 21742 USA 1322 Potomac Ave. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Salesman Auto Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Judith Merle Stang Glenn Webster Shorb, Sr. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 78 Redwood Drive Hagerstown, MD 21740 Judith S. Shorb - Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of I Important: If it 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dopation 5 ☐ Other (Specify) injury or cemetery, crematory or other place) 06-11-2011 Frederick, Maryland Mt.Olivet Cemetery 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 21. Sign 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final SHOCK WIMN Physician/ disease or condition Medical resulting in death) Examiner Priadory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 10 peen: 24b Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has! page 2 performed 2 No 1 Yes 25. Was case referred to edical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manne of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending ■ Natural injury work? 2 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

IW-3

State Registrar

Medical

29a. Certifier

30. Name and

(Check

only one) 29b. Signature 3 🗌

death (Item 23a) (Type, Print)

strar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month David Warren Shaw 4 Th 409 PM 2011 JU~ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 13012 Woodburn Dr. Washington County Hagerstown 5. Social Security Number 6. Sex 1 XM 2 ☐ F If Under 7. Age (In vrs. last birthday) 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min JUIV 34 1925 217-18-7862 **Director** 85 Maryland Usual Residence of Decedent I Hygiene. other than "natural", or items 23a or 28a-f show rent, the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Washington County Hagerstown 1 Tyes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 13012 Woodburn Dr. 21742 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) General Manager Supply Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H pertiti. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Nathaniel Ellsworth Shaw Nettie Austin Benson Shaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura S. Warford-granddaughter 13012 Woodburn Dr. Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rest Haven Cemetery 6-11-2011 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hely failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Kenel disease or condition resulting in death) Cell Mi Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): s gned by the attending physician d be detached for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>중</u> or Attending Physician: The law requires 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as pag∈2 s autopsy certificate 2 No 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗷 No 1 Tyes Other: Certificate: To Granddoughter 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 M Other (Specify) 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 4 Jmo 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 41667 6.6.11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month

Baltimore.

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 31^{Day} May 201^Y1 11:25 PM Frances Mae Shimansky Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Citizen's Care & Rehab Center Frederick Frederick Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🖾 F Min. August 1923, 1923 Mary land **Director** 220-16-4157 Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Frederick Emmitsburg 1 XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 21727 United States 401 W. Lincoln Avenue, #215 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🛛 No Specify: White "natural", Completed 3 Wildowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Iron & Steel Company permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Wade Stull Mary Poole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 W. Lincoln Ave., #215, Emmitsburg, MD 21727 Karen S. Shimansky / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) June 2, 2011 Frederick, Maryland Resthaven Crematory 4 ☐ Donation & ☐ Other (Specify) 21. Signatury of Fin Resthaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1. Enter the disease shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Interval Between Onset and Death Physician a Pulmonary Fibrosis vears Medical resulting in death) Examiner Chronic Obstructive Pulmonary Disease vears Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death signed by the a d be detached fi Yes 2 XX No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Division of Vital Records, To the Hospital or Attending Physician: The law requires Hypertension, Coronary Artery Disease, Atrial Fibril-Completed 1 Yes 2 No 3 Probably 4 Unknown lation, Dementia, TIA, Anemia, Hypothyroidism 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death? performe 1 Yes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 15 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending after death.

Director: Aft 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🛣 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

State

1900 Rosemont Ave.,

32. Registrar's Signature

Frederick, MD 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C.R.N.P.A.

Claire Pieri,

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Rose Marie SMITH 2:50 PM 2011 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Western Maryland Hospital Center Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 21,1952 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 58 219-60-2640 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d Inside City Limits show 28a-f sh notified 1 X Yes 2 □ No Director Maryland Washington Hagerstown the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or be ns 23a (must b 988 W. Irvin Avenue 21742 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify: white β 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 7 is marked other than "natu traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) lab technician hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ollie Bush Clarence E. Smith 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Smith - sister 988 W. Irvin Ave., Hagerstown, Maryland 21742 Important; If Item any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 6/8/11 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enjoy the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Esquentiary net conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Examine CEREBAL ANEURYSM burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician The law requires that the death certificate be Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 4□Pregnant at time of death in the past 12 months? Month Year Dav 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Wiknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEIZUME DISORDEL 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Worknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐ Yes 2 ☐ No 2 1 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4X Nursing Home 5 Residence Certification: To 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number
D 0 064 911 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 66/66/2011

JW-3 State

31. Date filed (Month,

ABDULL AH, M9 Hagerstown, MD 21742

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Pennsylvania Avenue

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral Director		5. Social Security N 064-26-3	290	6. Sex 1 □ M 2 🙀 F	7. Age	(In yrs. la	ast birthday) Yrs.	Month:	ler 1 Year S Days	If Under 24 Hours	Hrs. Min.	8. Date of Bi		31	9. Birthp Coun New	place (State or Foreign try) York
and show	ō	Usual Residence of 10a. State	10b. County		10c. City, Town or Location										1	0d. Inside City Limits
Maryla 28a-f s	rect	Md.	Prince	Georges	es Adelphi										1 🗆 Yes 2 🔀 No	
h the	a D	10e. Street and Nu	mber			10f. Zip Code							10g. C	g. Citizen of What Country?		
ms 2%	ted by Funeral Director	2000 Da:	na Driv										USA			
er des or ite miner		11. Marital Status 1 Never Man	ried 2 🔀 Mar	Armed F	Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No					Puerto F	pecify Yes or No- o Rican, etc.) 14. Race - Ame Black, Whit				,	
ural", ural", Il Exal		3 🗆 Widowed	4 Divorced	If Yes, G Year or D	, Give 1 ☐ Yes 2 🖾No Specify:									Specify:	Whi	te
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's N		hip <i>(Type, Print)</i> intini/Hus	ehan	d						Route Numb			tate, Zip C	Code)
f Healf f Healf item 2		20a. Method of Dis			3 Dan	20b. P	lace of Dispo	sition (N	ame of			ate 2		Location -	City or To	own. State
Page lent of				3 ☐ Removal from	n State		emetery, cren e of H	-							•	
permit. I Departm Importa any inju once.		4 Donation 5 Other (Specify) Gate of Heaven Cem. June18,2011 Silver Sp. 21. Signature of Funeral Service Licensee M01315 22. Name and Address of Facility DeVo1 Funeral Home													ing, in.	
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		shock, or hea	urt failure.List	complications that only one cause on e	caused each line.	the deatl	h. Do not ente	er the mo	ode of dying	g, such as car	rdiac or	respiratory a	rrest,			Approximate Interval Between
Physician/ Medical		Immediate Cause disease or condition resulting in death)		a	ART	nac	uence of):	RH	YTHE	niA					\perp	Onset and Death
Examiner		,					- F1									
	iner	Sequentially list co if any, leading to in cause. Enter Under	nmediate				ience of):			10-0					\dashv	
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eath certifica attending p	Physician/Medical	IF FEMALE: 23b. Was decedent		23c. If yes, ou] Fotoni	o pregnanci					23d. Date of delivery		
death he attu ied for	sicia	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknowr	No	4 Pre 9 Uni	gnant at			Other (у				Mor	nth	Day Year
requires that the der been signed by the s should be detached				ons contributing to	death bu	it not res	ulting in the u	nderlyin	g cause give	en in Part I.		23e. Did	tobacco	use contri	bute to th	ne cause of death?
ires the signer of the signer	d by											1 🗆	Yes 2	2 🗆 No	3 🗌 Prob	pabiy 4 Unknown
w requ	Completed											24a. Was				osy findings available
The lar ate ha bage 2	mo												opsy ormed? 2 41	, d	eath?	mpletion of cause of
or Attending Physician: The law requires that the death certificate be after death. Infer death. Infercor: After this certificate has been signed by the attending physic in by the funeral director, page 2 should be detached for use as the but.	Be (25. Was case referrexaminer?		Lines itali						ce of Death ((Check					
Physi this c	٠ <u>.</u>	1 Yes 2	No h	Hospital: 1 28a. Date			ER/Outpatien	it 3 🗆		4 LI Nursi		ne 5 🗆 Res)
nding ith. : After s fune	cate	1 Natural 2 Accident	5 Pendii	ng (Mo.	nth, Day,	Year)	injury	М	28c. Injury work?			8d. Describe	now inju	iry occurre	d	
tal or Attending Physician: The state death. al Director: After this certificated in by the funeral director, pred in by the funeral director, pred in the funeral director directo	Certificate:	3 Suicide 4 Homicide	6 Could	not be 28e. Plac	e of Injur	y - At ho (Specify	me, farm, stre	et, facto	ory, office		2				r or Rural	Route Number,
iital ol urs aft ral Dii lled in			_/								\perp	City or To				
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	(Check 2	2 U Medical I	Physician: To the Examiner: On the ba	asis of ex	amination	n and/or invest	igation, i	n my opinio	n, death occu	irred at t	he time, date	and plac	e, and due	to the cau	use(s) and manner stated
Nithin Vithin To the	Σ	29b. Signature and	title of certifie	Nurse Practioner	: To the b	est of my	y knowledge, o		urred at the Oc. License		nd place	, and due to the		(s) and mar ate signed		
, m		11/3	DORW						DY	0324				UNE		**
17.31		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TENNY JOD RIE, MD, FARDP 7600 CARROW AVENUE, TAROMA PARK, MAR														
- 01-		31. Date filed (Mont	th. Dav. Year	(WE) THE	Registro	's Signac	CITIC	سادلا ن	- 400	.002	J V]	-chrid	(1)	ion, i	MAC	14110
Stat Registra		JUN 2 1	2011	Geneva 32.	registral	40	Kel									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day **Physician** 2011 19 5:42A Margaret Strong /Medical Anna 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Potomac Under 1 Year If Under 24 Hrs. Montgomery Byron House Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Months Hours Min 1 □ M 2 □ F Director 220-10-7740 1-19-1916 95 MD Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at Yes 2□No Director MD Potomac Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20854 USA 9210 Kentsdale Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🟋 No Specify:White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns any injury or other traumatic event, the Media once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter A. McKenzie Katherine Boch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joan Sarfino Dauq. <u> 10213 Farmham Dr. Bethesda, MD. 20814</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Saint Peter's Cem 4 Donation 5 ☐ Other (Specify) 5-23-11 Westernport, 22. Name and Address of Facility 21. Signature of Funeral Service License Fredlock Funeral Home 31 Jones ST. Piedmont, WV 26750 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician achronic obstructive pulmonary disease disease or condition resulting in death) /Medical Examiner cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed atrial fibrillation and burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown hyprothyroidism 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an colon cancer hypertension , page 2 s autopsy performe or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASSISTED 217 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To After this 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

after death. filled in by within 24 hours a To the Funeral C Hospital completely

Medical

Lynne D. State Registrar

29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Mor

30. Name and address of person who completed cause of beath (Neg 23a) (Type, Print)
Lynne D. Diggs, M.D., 10400 Connecticut Ave#206, Kensington, MD 20895 Fegistrar's Signatur

and manner stated.

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

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RECEIVED MAY 23 7011 RECEIVED MAY 2 3 200

29d. Date signed (Month, Day, Year)

5-23-11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 28° 2011 Ozora Evelyn Partridge Salmon 10:42 P.M Mav Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14808 Claude Lane Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Hours May 13, Year 1919 Atlanta, Georgia 255-32-2702 92 Director Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14808 Claude Lane 20905 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 72 hours after Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r 2 college (1-4 or 5+) years Elementary/Seconday (0-12) U.S.Dept. of Labor Secretary Typist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Estella Melvina Holston Floyd Partridge, Sr. 19a. Informant's Name/Relationship (Type Print)
Pauline Ruby Partridge Holton (\$1ster) Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14808 Claude Lane; Silver Spring, Maryland 20905 <u>Lenair Delano Holton (Nephew)</u> or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot June 6,2011 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) National Harmony Memorial Park Landover, Maryland Signature of Funeral Service License 22. Name and Address of Facility R. N. Horton Company Morticians, schrideren Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Adult Failure To Thrive disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Debility Sequentially list conditions, if any, leading to immediate cause. Enter chaenying Due to (or as a consequence of) Exami The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Unknown 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? this certificate Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) neral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D37142 June 1, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

JUN 0 7 2011

Geoffrey Coleman, M.D.; 1355 Piccard Drive; Rockville, Maryland 20850

32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 28, Physician/ 2036 Lawrence D. Scarborough 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Constant Care Assisted Living Capitol Heights If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) DC 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 54 Hours (Month, Day, Year) 578-80-4918 **Director** March 4. 1957 Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland octant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director tXX Yes 2 ☐ No MD Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20743 United States 1213 Doewood Lane permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene, Important; if item 27 is marked other than "networn" any injury or other terms. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2X No Specify: If Yes, Give Black Specify: 3 Divorced 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 8th College (1-4 or 5+) Private Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Scarborough Blanche Faison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 382 Harry S. Truman Dr., Largo, MD 20744 Brenda Tinner/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State June 7,2011 Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service License 5538 Marlboro Pike Forestville, MD 20747 M0103 23a. Part 1. Briter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): requires that the death certificate be executed ending physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2- No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law has autopsy certificate l 1 🗌 Yes 2 🔲 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specifical Properties)} \) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 5 Pending death. 1 🗌 Yes Accident
Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar only one)

29b. Signature and title of certifier

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29c. License number

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After this certificate has

To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: A

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filled in by

29b. Signature and title of certifier

Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760,

Records, P.O.

Division of Vital

Physician /Medical

Examiner

If item 27 is marked

timore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Month Da May 30, 2011 0843 hrs SCOTT 4c. County of Death 4b. City, Town, or Location of Death Prince George's Hvattsville 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Hours Min 08-19-1950 60 Country) 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No WASHINGTON 10g. Citizen of What Country? 10f. Zip Code USA 70011 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-12. Was Decedent Ever in U.S. White, etc If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married 1 Yes 2 X No SIACK 1 Yes 2 No specify: If Yes, Give Year or Dates: 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) DRIVER TAXI 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ROSETTA SCOTI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 420 QUALICUMBUS ST NW WASH SON DL PADULCK SCOTT 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Perentale Park hementory Donation 5 Other Specify 21. Signature of Funeral Service Licenses 814 UPSHWSTNW 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Death Shotgun Wound of Abdomen Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last UNPENDED AMENDED 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 ✔ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? 2 No ✓ Yes 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene DOA ER/Outpatient 3 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury 27. Manner of Death

Physician/Medical Completed by Be Subject shot Certification: May 30, 2011 0835 hrs 1 Natural 1 Yes 2 ✓ No Pendina 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) 900 Chillum Road, Hyattsville, MD (Specify) Vacant Lot 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Cal

29c. License number

O.C.M.E.

Zabiullah Ali, M.D. 31. Date filed (Month, Day Year) State Registrar

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year)

May 31, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month David A. Sewell 2011 9:46 Medical June 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgamery Takoma Park 8. Date of Birth (Month, Day, Year) 07/12/1955 If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Min. Hours Country) Director 579-70-3346 Washington. TY Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince Georges Laurel 10f. Zip Code 10g. Citizen of What Country? Funeral 12703 Silverbirch Lane 20708 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Never Married 2 XMamied Completed by Specify: Black 1 ☐ Yes 2X No Specify: "natural", If Yes, Give 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Driver Dan Daniels Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Bernard Sewell Thalia Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shument of Health a tant: If item 27 is Kyra Sewell (Wife) 12703 Silverbirch Lane Laurel, MD 20708 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If if any injury or o cemetery, crematory or other place)

Chesapeake Crematory 06/03/2011 Beltsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Poheral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Maryland 20706 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, prock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and -transit Cause (Disease or iinjury that initiated events resulting in death) Last death certificate be executed Due to (or as a consequence of): nding physician a Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown ned by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Ves 2 140 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: မ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 LER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27. Manner of Déath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at filled in by the funer 28d. Describe how injury occurred 1 Matural 5 Pending injury work? 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours of To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 0006 olis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

JUN 0 7 2011

32. Registrar Signatur

A Hmina

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 610 Thomas Dorothy Jeanne 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Memorial STOI albot Social Security Number If Under 24 Hrs. Age (In vrs. last birthday) If Under 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Min. Dec. 9. 1938 1 M 2 X F Pennsylvania 213-36-6115 72 Yrs. Director Usual Residence of Decedent 10b. County an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at 10a State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Dorchester Cambridge 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1005 Roslyn Avenue 21613 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc by 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify. white Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit, Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) administrative assistant doctors office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 George Eugene Stern Dorothy Gauntz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James P. Thomas husband 1005 Roslyn Avenue, Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 6/7/11 22. Name and Address of Facility 21. Signat van f Funeral Service Licenses Thomas Funeral Home P.A. Cambridge, MD 700 Locust St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day 2 No the 1 ☐ Yes 2 ☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown within 24 hours after death.

To the Funeral Director: After this certificate has been are subject to the funeral director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 🗖 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospita Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Manner of Death Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature License number

DHMH 17 Rev 7/2009

State Registrar 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

chus

31. Date filed (Month, Day, Year

1 Mai

11-04402 Mary Tierney

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mary Tierney	State of Maryland / Department o		lygiene 201	19815
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year June 11, 2011	3. Time of Death 1620 hrs
	4a. Facility Name (if not institution, give street and number) 198 Boones Drive	4b. City, Town, or Location of Deatl Lothian	4c. County of Dea Anne Arundo	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 216−50−6821 1 M 2 ▼ 60 Yrs	If Under 1 Year If Under 24Hr. Months Days Hours Mir		Birthplace (State or eign Maryland Country)
м апу	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local			10d. Inside City Limits
th the Maryland 23a or 28a-f sho antified at once.	Maryland Anne Arundel Davids 10e. Street and Number 3476 Savannah Drive	onville 10f. Zip Code 21035	10g. Citizen of What Co	1 Yes 2 X No
215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. riced other than "natural", or items 23a or 28a-f abeent, the Medical Examiner must be notified at once Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	is Decedent of Hispanic Origin? (S es, specify Cuban, Mexican, Puerto	pecify Yes or No- 14. Race - Am	erican Indian, Black,
nours after datural", or	3 X Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Deceder division of division of the second states.	Yes 2 X No specify: It's Usual Occupation (Give kind of ost of working life, DO NOT use ret	work done 16b. Kind of Busines	nite s/Industry
5-0036 led within 72 hour Hygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 11 17. Father's Name (First, Middle, Last)	Homemaker	Homema	ker
2 5 6 8 g 0	Joseph L. Bielaski	Agnes	e (First, Middle, Maiden Surname) M. Spaulding Rural Route Number, City or Town, Sta	sto. Zin Coda)
	Barbara J. Bielaski / sister 3476		Davidsonville, MD	21035
	1 Burial 2 X Cremation 3 Removal from State crematory or ot Kalas C	rematory 06/	15/2011 Edgewate	r, Maryland
	1000000 29	73 Solomons Isla	rge P. Kalas Fune nd Rd., Edgewater	, MD 21037
Physician /Medical £xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of)			Approximate Interval Between Onset and Death
5	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate the conditions of the conditi			
ted J snsit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			1
O, be executed sician and burial - transi edical E)	▼ UNPENDED ☐ AMENDED 23a, pt.II, 27, pc	er me,g916 6-22-	llsm	
lox 6876 teath certificate eattending phy for use as the /sician/M	Pregnant at time of death	tal death 3 Ectopic pregni her (Specify)	23d. Date of delive Month	ery Day Year
signed by the standard by the detached by by the detached by the bedtached by the by the by	Part II. Other significant conditions contributing to death but not resulting in the under Diabetes	inderlying cause given in Part I.	23e. Did tobacco use contribute t	
of Vital Records, P.O. ag Physidan: The law requires that it there this certificate has been signed by meral director, page 2 should be detact or: To Be Completed by P.			autopsy prior to death? 1 ✓ Yes 2 No 1 ✓	
Vital ysiclan: his certif director,	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26.Place of Death (Check 3 DOA Other Nursin	only one) ng Home 5 Residence 6 Oth	ner: Scene
- = · ` 4 5	27. Manner of Death 1	njury 28c. Injury at Work?	28d. Describe how injury occurred	
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune- ledical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street (Specify)	et, factory, office building, etc.	28f. Location (Street and Number or F or Town, State)	Rural Route Number, City
DIVI To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Certifi	29a. Certifier 1			
	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (M June 12, 2011	fonth, Day, Year)
HO	30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. I	Baltimore Street, Baltimore	, MD 21223	
State Registrar		ake		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	Amend Item 16aState of Maryland / Depa State WCHD/TF 6/3/2011 per FH Cer	artment of Heartificate of De	alth and Meath	ental Hygier Reg. I 2. Date of Death		9850		
Physicia /Medic	an al	Decedent's Name (First, Middle, Last) Donald Guyer Turner			June 2,		6:00 a M		
Examin	er ⁴	a. Facility Name (If not institution, give street and number) Golden Living Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)			8. Date of Birth (Month, Day, Ye.	Washing Washing (ar)			
Director		218-24-1383			2/24/1931		ryland 10d. Inside City Limit		
permit. Pages I and 2 stoud be lied within 2 from a are focus may be be permit in more page. Department of Health and Mential Hydrachining interaction of Health and Mential Hydrachining interactions as marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, if a Medical Examinar must be notified at once.	rai Director	MD Washington Hage 10e. Street and Number 524 George Street 12 Was Decedent Everin U.S. 13.	rstown 10f. Zip Code 21740 Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Spe	Cify Yes or No-	1 Yes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc.			
n "natural", or ite decisal Examins	Completed by Fu	1 Never Married 2 Married 1 Yes 2 No It Yes, Give Year or Dates: 15. Decedent's Education 16a. Dece	dent's Usual Occupation kind of work done during DO NOT use retired)	Specify: n ng most of worki			White Kind of Business/Industry		
al Hygiene I other tha	Be Com	8 Fabri 17. Father's Name (First, Middle, Last)	catur		(First, Middle, Main				
h and Ment. 7 is marked Iraumatic e	인		ing Address (Street and	Number or Rura		ity or Town, State			
popartment of Heali Important: if Item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee		k 6/4/	2011 Ha st Haven	e Location - City gerstown Funeral	, Maryland Chapel		
hysician ophisician and provided and the price reason and the price reas	dical Examiner	23a. Part1. Enter the disease, or complete tions that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ter the mode of dying, s				Approximate Interval Between Onset and Death		
by the attending phy tached for use as th	Physician/Med		□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year		
n signed b	þ	Part II. Dther significant conditions contributing to death but not resulting in the	undertying cause given	in Part I.	23e. Did toba	V	e to the cause of death] Probably 4 □Unkr		
icete has been signed by the page 2 should be detache	Completed					prior death	e autopsy findings avai to completion of cause h? Yes 2 \(\sum \text{No} \)		
r death. •ctor: After this certificet by the funeral director, p	ation; To Be	25. Was case referred to medical examiner? 1	ent 3 DOA Others of 28c. Injury a Work?	4 Dursing H	th (Check only one) ome 5 Residen 28d. Describe how		Specify)		
within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, Iarm, s building, etc. (Specify)			City or Town,	State)	r Rural Route Number,		
in 24 hou hs Funst pletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opin	nion, death occu	rred at the time, dat	e and place, and	due to the cause(s)		
Tor	2	29b. Signature and title on certifier	29c. License	6323	3	d. Date signed (N	12011		
St Regis	ate	30. Name and address of person who completed cause of death (Item 23a) (Typo 31. Date filed (Month, Day, Year) 32. Registrar's Signature	e, Print)	lagers	town mi	יקוב כ	Y 2		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11: 30PM IIMPSON GREGORY Allen 2011 Medical 4a. Facility Name (if not institution, give street and number) Town or Location of Death 4c. County of Death **Examiner** S South FREDERUR FREDGRIUR LAST Social Security Number 1 Year If Under 24 Hrs. If Under 8. Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 213-58-265 1 M 2 D F Months Min 59 Yrs Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD FREDERICK FREIDERIUR Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be re-Funeral EXST SOUTH SI 21701 ZV hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates. 1968 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DISABLED should be filed with and Mental Hygien 7 is marked other th 1294 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 WILLARD SPENCER THUPSON ALLEN CAROLYN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh
Department of Health a
Important: If item 27 is
any injury or other tra (DAU) PARTHESON DAWN AXFORD DR. NEWNER DELAWARE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 31 2011 SMITHEBURG, MD 5M MYSBURG MAY 4 ☐ Donation 5 ☐ Other (Specify) ROLLING FUNDER HOME 21. Signature of Funeral Service License 22. Name and Address of Facility AR Rolling June Z. FRED GRUCK MARY LAND 21701 8 BOURTH 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician. disease or condition resulting in death) Medical r as a consequence of ≟xaminer Sequentially list conditions Examine trany backing to the medicause. Enter Underlying Cause (Disease or iinjury that initiated events that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of) physician sthe burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as t attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No ρ Month Other (specify) Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 Tes Completed peen 24b. Were autopsy findings available 24a. Was an this certificate has page 2 autopsy prior to completion of cause of death? 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 2 1 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After t 1 Natural 5 Pending injury 1 🗌 Yes 2 🗌 No hours after death. Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month) 110 Baughmar Frederick m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ane 5

Registrar

State

31. Date filed (Month, Day, Year)

Barke

32. Registrar's Signature

21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Tobin .TYPE 12. Day 2011 Year Lillian Physician/ 4:30A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Rockville Montgomery Hebrew Home of Greater Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Oct. 4. 1915 NY New York 053-07-3357 **Director** Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 1 🗆 Yes 2 🗀 No Rockville Montgomery Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or than "natural", or items 23a or the Medical Examiner must be 20852 1801 E. Jefferson Street, #412 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Yes þ 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates Specify: White Completed 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the action of the traumatic event the action. College (1:4 or 5+) Elementary/Seconday (0-12) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lakretz Nidich Mollie 2 Samuel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zin Code) 8330 N. Brook Lane Bethesda, Mary Land 20814 Jane Rosov -daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 6/15/2011 Olney, Maryland Judean Mem. Gardens 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Dönaldov. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Advanced Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cauca. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 5 Other (specify) Pregnant at time of death signed by the at d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director: After this certificate has b completed filled in by the funeral director, page 2 sl autopsy performed' death? 1 Yes 2 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 🔀 No 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident Suicide 5 Pending 1 🗌 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6-13-2011 min 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville Fazl1 MD Moistruse 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

varke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month 05 ď₹ 20°1'1 Trite, Jr. 2:00 AM Charles Edward /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 628 Apple Avenue Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Months Days 1952 Director 219-60-4095 58 11 23 Waynesboro, PA Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County items 23a or 28a-f show Exercitive must be notified at Hagerstown MD Washington 1 ☐ Yes 2 XNo Funeral Director 10e. Street and Number 10g. Citizen of What Country? 21742 21722 Leitersburg-Smithsburg Rd. US permit. Pages 1 and 2 should be filed within 72 hours after death \(\text{Department of Health and Mental Hygiene.} \) Important: If Item 27 is marked other than "natural", or items 23; any injury or other traumatic event, the Wedical Exerciter courts once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🖔 No þ Specify Specify: white 3 ☐ Widowed 4 1 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) equip, company welder 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Betty Joyce Baker Charles Edward Trite, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Billie Jo Smith daughter 628 Apple Avenue Frederick MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/11/2011 Cascade, MD Bethel Church Cem. 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc 21. Signature of Funeral Service Licer les Waynesboro, PA 50 S. Broad St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BECOMU /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examine if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home Statesidence 6X Other (Specify) Residence Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only To the P 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD

State Registrar 31. Date filed (Month, Day, Year)

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hnson

Thomas

Registrar's Signature

Drive; Frederick, MD 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

46 B

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 2, 2011 9:05 Ам Andrew W. Tate, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton 5337 West Boniwood Turn Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, 66 Months Days Hours Min. Director Ĭ944 578-56-0790 DC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 No Clinton Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20735 United States 5337 West Boniwood Turn 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Government Educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernice Minor Andrew W. Tate, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5337 West Boniwood Turn Clinton, Maryland Luevonia L. Tate - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June 8, 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State Lee's Crematory Clinton, Maryland 4 Donation 5 Other (Specify) 2011 21. Signardire of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home, ceway 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line gnset and frath Immediate Cause (Final Principan/ Prostate Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events resulting in death) Last Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 1 Yes 2 No ed by the been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypercalcemia 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed cate has been signated by page 2 should by 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? After this certificate 2 No 1 Tes Yes 25. Was case referred to medical B 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 🐴 No Other: မူ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 A Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Director; / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signat e and title of ce 29d. Date signed (Month, Day, Year) D0025344 30. Name and address of person who complete ed cause death (Item 23a) (Type, Print)

Registrar

National Drive # 220

3905

32. Registr

J.

31. Date filed (Month, Day, Year JUN 0 7 2011

Robert

Ginesberg

20866

Burtonsville, Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201 Samuel Lee Thompson Sr. May 28 7:00 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Fort Washington Prince George's Fort Washington Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year March 5, 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 ∰ M 2 □ F Months Days Hours Min Country) New York Director 200-54-8634 43 1968 Usual Residence of Decedent shov Page 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hyglene.
 Kant: If item 27 is marked other than "natural", or items 23a or 28a-f sho luny or other traumatic event, the Medical Examiner must be notified at luny or other traumatic event, the Medical Examiner must be notified at "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Upper Marlboro 1 A Yes 2 No Prince George's Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 10005 Oakengate Drive 20772 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African American If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Improvement - Roofer Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Stephen Butch Gary Willie Mae Gary Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Rennetta Mason - Sister 6206 Cedar Post Drive Forestville, Md. 20a. Method of Disposition permit. Page 1 a
Department of h
Important: If ite
any injury or ot 20h Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 A Burial 2 Cremation 3 Removal from State June 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland Resurrection 2011 21. Signature of Foneral Service Licen 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition Medical resulting in death) as a consequence of): (0 Examiner Sequentially list conditions, Examine Due to (or as a consequence of, If any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day be detached signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed certificate 2 🗌 No 1 Tes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **2** No ဂ္ 1 Yes Other 1 Propatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director, A Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer-29c. License number

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month,

JUN 0 7 2011

Amir Mirza-Alikhani 11711 Livingston Road Fort Washington, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ WILLIELEE THOMPSON 2:50 P .M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GENESIS CRESCENT CITIES PG RIVERDALE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 **X** M 2 □ F 1070171934 Fitler, Miss 76 Director 577-46-7034 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director District Heights 1 X Yes 2 No Md. Prince George's 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 6124 Surrey Square Lane 20747 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Specify: 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Truck Driver 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Beatrice Fleming Isadora Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6124 Surrey Square Ln., District Heights, Md. 20747 19a. Informant's Name/Relationship (Type, Print) Carolyn Thompson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 Burial 2X Cremation 3 Removal from State Chesapeake Crematory, Inc. 06/10/1 Beltsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee ²² Henry S. Washington & Sons Co., Inc. raci anu 4925 Burroughs Ave., N.E., Washington, D.C. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final EMENTIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) 27. Manper of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending work 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Playsician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examinet: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

SAADIA KUSAI 31. Date filed (Month, Day, Year, JUN 0 7 2011

29b. Signature and title of certific

30 Name and address of person

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mpleted cause of death (Item 23a) (Type, Print)

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State

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29d, Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Linda Jean Vargas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ENTER ata If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Min March 2, 1953 Virginia Months Hours 215-64-5799 **Director** 58 Usual Residence of Decedent or 28a-f shov 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director Y Yes 2 ☐ No Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 11 Elder Place 20640 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: "natural", 3 Widowed 4 Divorced Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N U.S. Government Procurement Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl Thomas Milligan Annie Lois Grimsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 Oakside Lane, Indian Head, Md. 20640 Daughter Consuela A. Vargas 20b. Place of Disposition (Name of cemetery, crematory or other place June 9, 2011 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens 21. Signature of Funeral Service Williams Funeral Home, P.A. M00668 20640 4270 Hawthorne Rd., Indian Head, Md disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Ent Interval Betwee Approximate shock, or heart failu Immediate Cause (Final art failure. List only one cause on each line Pnysician Cardionyopar LSchemic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner oronary Artery Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying (or as a consequence of) sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): ending physician use as the burial Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached f P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hyponalyema Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 onknown Completed Kidney Distare Sture III 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s performed Yes 2 death? 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 / No 1 🗌 Yes မ Inpatient 2 ER/Outpatient 3 DOA hin 24 hours after death.

the Funeral Director: After this appleted filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Division 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated D46419 completed cause of death (Item 23a) (Type, Print) GARRETT AVE La Plata MA 20646

Registrar DHMH 17 Rev 7/2009

State

harlene 31. Date filed (Month, Day, Year)

288

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Tyler Carlton Wedding June 5 2011 1:23 a.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 23 Delta Place Indian Head Charles If Under 1 Year | If Under 24 Hrs. . Social Security Number 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, **Funeral** Sex 1 **∆** M 2 □ F 7. Age (In vrs. last birthday) Min 214-58-0171 Director Sept. 1953 6, Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Maryland Charles Indian Head 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23 Delta Place 20640 U.S.A. "natural", or items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 Yes If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced White Year or Dates other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Self Employed Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o ည Nettie Marie Aiello Fred Wilbur Wedding, Sr. and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Wife Sallie Ruth Wedding 23 Delta Place, Indian Head, Md. 20640 Place of Disposition (Name or cemetery, crematory or other place)

June 6, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 2011 injury o 4 Donation 5 Other (Specify) Alexandria, Virginia <u>Metropolitan Funeral</u> Signature of Funeral Service Lic Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Part 1. Errer the disease, or complications that cause shock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or imputhat initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) anding physician are as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b lirector, page 2 sl autopsy performed' death? 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: မ 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Accident 5 Pending work' 1 Yes 2 🗌 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Fertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occ urred at the time, date and place, and due to the cause(s) and manner as stated

763 State

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifie

30. Name and address of person

31. Date filed (Month, Day, Year

who completed cause of death (Item 23a) (Type, Print

29d. Date signed (Month, Day, Year)

MD 20646

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		State Registrar			Cer	tificate of I	Death		Reg. N	ю.		19859
Physic	an/	Decedent's Name (First, Midd						2. Date of D Month JUNE		Day 2	ŎĨ1	3. Time of Death
Med Exam		JOHN NEWMAN V				4b. City, Town, o	r Location of		_	Ic. County		12:00 P M
Funera		CHESTER RIVER 5. Social Security Number	HOSPITAL C	,	birthday)		ERTOWN				ENT	place (State or Foreign
Directo	711-07-2953 1 M 2 ☐ F 93						Hours	7191	18 MARYLAND			
land show	tor	10a. State 10b. Count	у	10c. City, 1	Town or Lo	cation					1	10d. Inside City Limits
Mary 28a-1 otifie	irec	MARYLAND QUEEN	ANNE'S	CHE	STER							1 🗌 Yes 2 🗶 N
ith the	ral	10e. Street and Number 225 DOMINION	ROAD			10f. Zip Code	619			Citizen of V ITED		· ·
ire, Maryland 21215-0036 If and 2 should be filed within 72 hours after death with the Maryland If health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	ed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma 3 ★ Widowed 4 □ Divorce	12. Was Decede Armed Force 1 M yes 2	es? No			lispanic Origi an, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)		14. Race		can Indian, etc.
21215-0036 within 72 hours after glene. Per than "natural", of the Medical Exam	Completed by	(Specify only high Elementary/Seconday (0-12)	ent's Education hest grade completed) College (1-4		(Give I life. D	lent's Usual Occup kind of work done O NOT use retired)	during most of	of working		Kind of Bu		dustry
aryland 2121\$ ould be filed within 72 nd Mental Hygiene. s marked other than " umatic event, the Mes	To Be C	8 17. Father's Name (First, Middle, JOHN QUINCEY A		as	112			's Name (First, Middle LLIAN MAE	e, <i>Maid</i> ei			
, Maryland d 2 should be filed alth and Mental Hy n 27 is marked oth or traumatic eveni		19a. Informant's Name/Relation PEGGY HALL / D				ng Address (Street BOX 441		or Rural Route Numb	per, City o	_	tate, Zip (Code)
Baltimore, bermit. Page 1 and Department of Heal mportant: If item: any injury or other any injury or other		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other		cem	netery, cren	sition (Name of natory or other plac LLE CEMET	ERY 06	Date 5/10/2011		Location -		
Baltimol permit. Page 1 Department of Important: If is any injury or once.		21. Signature of Funeral Service	Licensee	1 -	FE 10	Name and Addre	ss of Facility ELFENB	EIN & NEW , CHESTER	NAM MD	FUNER 2161	AL H	OME, P.A.
Physician Medica		23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each		Do not ente	er the mode of dyir						Approximate Interval Between Onset and Death
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68760 certificate be ex nding physician use as the burial			L d									
Box death death he atter	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 🗌 Fetal d nt at time of dea	eath 3	Ectopic pregnand Other (specify)	су			23d. Dat Mor		ery Day Year
S, P.O. ires that the signed by t	d by Pi	Part II. Other significant condit	tio ns contributing to deat	th but not resulti	ing in the u	nderlying cause gi	ven in Part I.					ne cause of death?
Division of Vital Records, all or Attending Physician: The law requires s after death. Indirector: After this certificate has been signed in by the funeral director, page 2 should be an in by the funeral director, page 2 should be all the funeral director.	Completed by							_ per	opsy formed?	p	rior to co leath?	psy findings available mpletion of cause of
//tal Rec sician: The lar certificate ha irector, page 2	Be C	25. Was case referred to medica examiner?				26. P	lace of Death	1 L Yes (Check only one)	5 2 (2 1)	NO	L 165	2 🗆 110
FVit Physic This ce	은	1 🗆 Yes 2 🔀 No		patient 2			4 ∟ Nur	sing Home 5 Res	sidence	6 🗆 Othe	r (Specify)
ion of Vital ending Physician: eath. or: After this certific	Certificate:	27. Manner of Death 1 PNatural 5 Pend 2 Accident Inves 3 Suicide 6 Could	tigation	injury 28 Day, Year)	Bb. Time of injury	28c. Injur worl M 1		28d. Describe	how inju	ury occurre	d	
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Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 ☐ Medical only one) 3 ☐ Certifyir	ng Physician: To the best Examiner: On the basis ng Nurse Practioner: To	of examination a	nd/or invest	igation, in my opini leath occurred at th	on, death occ ne time, date a	urred at the time, date	and place	ce, and due	to the car	use(s) and manner stat
P With P E		29b. Signature and title of certific	mm>			29c. Licens	F 036		29d. D	ate signed	(Month, 1	Jay, Year)
Dert		Gon) 1	who completed cause of	of death (Item 23	Ba) (Type, P	nut Dr	ine (Jerler,	M	02	161	, 9
St Regist	ate	31. Date filed (Month, Day, Year)	7 2011 32. Re	strar's Signature	A 1	a as I						

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State of Maryland / Department of Health and Mental Hygiene

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			1 - State Registrar		•	Certi	ficate of E	Death		Reg. No.		
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	Examir	ner	4a. Facility Name (if not institu Mandrin Hospi	,)	4	4b. City, Town, or Harw	r Location of Death	4c. County of Death Anne Arund			nde1
	Funeral		5. Social Security Number	6. Sex 7. A	Age (In yrs. last bir	st birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. B						ace (State or Foreign
	Director		330-26-0989	1 □ M 2 F	78	Yrs.	Months Days	Hours Min.	187237	1932	Count	
	nd now] _	Usual Residence of Decedent 10a. State 10b. Cou		10c. City, Tow	vn or Loca	tion				1/	0d. Inside City Limits
	arylar a-f sl	ectc	MD Anne	Arundel			River					1 Yes XX No
	or 28	直	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Count	ry?
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	death r item ner n	Fur	11. Marital Status	12. Was Deceden Armed Forces	?	13. Wa	s Decedent of Hi es, specify Cuba	ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America k, White, e	
336	e filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	1 ☐ Never Married 2 ☐ I	If Von Give	XI No	1 [Yes ¥ ፟ No	Specify:		Specify:	T.J	hite
Maryland 21215-0036	hour	olete		edent's Education ighest grade completed)	168	a. Deceder	nt's Usual Occup	ation		16b. Kind of Bu	ısiness Ind	ustry
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lary	and N is ma		19a. Informant's Name/Relation	onship (Type, Print)	19	b. Mailing	Address (Street a	and Number or Rui	al Route Number	, City or Town, S	tate, Zip C	ode)
≥,	und 2 : lealth im 27		Rebecca McDor	ough Ni			eWolfe D	r. Alex	andria,	VA 2230		
Baltimore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.			ion 3 🗌 Removal from Sta	te cemete	ery, cremai	ion (Name of tory or other plac		Date	20c. Location -	•	
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			23a a /l. Enter e dise (se shack, or he rt failure. L	e, or complications that caus ist only one cause on each li	ed the death. Do	not enter t	the mode of dying	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between
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-	Medical Examiner		resulting in death)	Due to (or a	s a consequence	of):						
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	To the H within 24 To the Fi complete	Me	only one) B Certify	a/Examiner: On the basis of ing Nyrse Practioner: To the	ie best of my know	vledge, dea	ath occurred at the	time, date and pla	ce, and due to the	cause(s) and ma	nfier as stat	ed.
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			30. Name and andress of pers	n who completed deaths of	Anti Marrosa	(Abe Prid	(a)	1	R	- V - V	1	4.03.031
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	Sta Registr		31. Date filed (Month, Day, Yea JUN 0	3 2011 32. Pegis	trar's Signature	Some	Ke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Time 04 2011 **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Nam (If not institution, 4c. County of Death **Examiner** Dorchest Garand Hagistan ampridge 8. Date of Birth Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs, last birthday) Min. 1 M 2 DF Days Hours Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No Directo 10g. Citizen of What Country? 10e. Street and Number Funeral 2. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary (Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, Father's Name (First, Middle, Last) Be ဂ 19b. Mailing Address (Street and Number or Hural Route Number, City or Town, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as calerac or respiratory arrest, shock, or heart failure. List only one cause __n each line. neymour-Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Fracture Re Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Dee to for se a consequence of resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 Na 1 □Yes 2 1 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\bigcap \) Nursing Home \(5 \bigcap \) Residence \(6 \bigcap \) Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Impatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No

To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and P.O. Box 68760. been signed by the attending physician should be detached for use as the burial Division of Vital Records, · has r page 2 s After this certificate director, funeral death. To the Funeral Director: , completely filled in by the f within 24 hours a

Funeral

Director

or items 23a or 28a-f show

"natural"

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient Important: If Item 27 Is marked other the any injury or other traumatic event, The ORGE.

Physician

/Medical

Examiner

death with the

Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

Maryland 21215-0036

Baltimore,

injury or other traumatic event, the Medical Examiner must be notified at

Certification: To

Medical

2 Accident

6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide

29b. Signature and title of certifier

29a. Certifier

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

 Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

CAMBRIDGE MD 21613

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOMAN 503

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signatur

and manner stated.

Warren, Joyco

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980	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 XI If Yes, Give Year or Dates.		If Yes,	Decedent of Hi , specify Cuba Yes 2 🔀 No	spanic Origin? (Sp n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Ra	ace - Amer ack, White	rican Indian, e, etc. White
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, Mar	nd 2 shoul ealth and I m 27 is m		19a. Informant's Name/Relationship Tracey Warren	(Type, Print) Son	19b.				ral Route Number, ton,MD 2		State, Zip	Code)
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Balt	permit. Departimport Import any inj		21. Signature of Emeral Service Lice	nsee		22. Nan Hard	ne and Addres	s of Facility uneral H	ome P.A.	851 A	nnapo	lis Road MD 21054
-1	hysician/ Medical	8 1	23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	the death. Do not	ot enter the	mode of dying	g, such as cardiac		est,		Approximate Interval Between Onset and Death
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	uted d ansit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events		CONFECUENCE C	,	1					
	te be executed lysician and ne burial-transit	I— I	resulting in death) Last	Due to (or as a	consequence of	f):						
. Box 68760	Attending Physician: The law requires that the death certificate be execut at death. actor: After this certificate has been signed by the attending physician and yet funeral director, page 2 should be detached for use as the burial-trains.	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome c 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal death	3	opic pregnancy er (specify)	у			ate of deli	very Day Year
ls, P.O	requires that the de been signed by the should be detached	ed by PI	Part II. Other significant conditions	contributing to death bu	t not resulting in	the underly	ying cause give	en in Part I.				the cause of death?
Division of Vital Records, P.O.	sician: The law req s certificate has bee lirector, page 2 shoi	Completed							24a. Was ar autops perfor	med?	prior to c death?	opsy findings available ompletion of cause of
/ital	Physician: 1 this certificaral director, p	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Othe	r: —				
n of \	nding Phy tth. : After this s funeral d	cate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,	nt 2 ER/Out 28b. Til Year) inj		28c. Injury work?	at	ome 5 Reside 28d. Describe ho			59)
		Certificate:	3 Suicide 6 Could not determined	be 28e Place of Injur					28f. Location (Str City or Town		per or Rura	al Route Number,
-	To the Hospital or within 24 hours after To the Funeral Dirucompleted filled in 1	Medical	(Check 2 L Medical Exar	ysician: To the best of n niner: On the basis of ex arse Practioner: To the b	amination and/or	investigatio	n, in my opinior	n, death occurred a	at the time, date an	d place, and du	ue to the ca	ause(s) and manner stated.
	To the within 2 To the comple	_	29b. Signature and title of certifier	, Q.			29c. License			9d. Date signe		
	/		30. Name and address of person who	completed cause of de			U D	ი 53 7. r. Berha	0'3 ne	June		, 2011
	No.		SATIMONT 31 Date filed (Month Day Year)	a Azure	ו מענ	non	ica	Cin	ur,	CLE	U 13	Purant of
	Stat Registra		JUN 0 6	201 32. Registrar	ww B	. po	ake					

11-04062 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Will Weathersby State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day May 31, 2011 1057 hrs **Medical Examiner** Will Weathersby 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c County of Death 35 N. Conococheague Street Williamsport Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 1 XM 2 F Mississippi 426-80-4687 Yrs 69 Sept.24,1941 Usual Residence of Decedent 10a, State 10b County 10c City Town or Location 10d Inside City Limits 1 X Yes 2 No or 28a-f show nent of Health and Mental Hygiene. kant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.
nnt: If item 27 is marked other than "natural", or items 23a or 28s-f sho Maryland Washington Williamsport Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 35 N. Conococheague Street Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14, Race - American Indian, Black, White, etc. African If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 Never Married If Yes, Gively 9,75-1979 3 Widowed 4 X Divorced 1 Yes 2 X No specify: American ۵ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baitimore, MD 21215-0036 12 Maintenance Leather Tanning 17, Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Galloway Thomas Be Weathersby McInnis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki Weathersby-Daughter 1084 Ross Street Hagerstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State June 6,201 Hagerstown, Maryland Hagerstown Crematory Conation 5 Other Sp Oslanda de nerad Home, P.A. of Funera 425 S. Conococheague St. Williamsport, MD 21795 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical attending physician or use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the icate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed death? ✔ Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26 Place of Death (Check only one) Be Hospital: 1 Inpatient Other 4 Nursing Home 5 Residence 6 🗹 Other Scene ER/Outpatient 3 1 🗸 Yes funeral o 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c, Injury at Work? 28d. Describe how injury occurred 1 V Natural 5 Pending 1 Yes 2 No the Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Homicide 29a. Certifier 1 completely i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

- 1/2+ State Registrar

OCME 2006

DHMH 17 Rev 1/2001

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number OCME

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

31. Date filed (Month Care 2011

Ling Li, MD

29d. Date signed (Month, Day, Year)

June 1, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month (Mary Elizabeth Wolford 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F May 12, 1958 Mary land Director 213-92-5268 53 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1380 Marshall Street 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 1 X Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 2 X No 1 ☐ Yes 2 X No Specify: and Mental Hygiene. is marked other than "natural", Specify: White 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)
NA NΑ NΑ NA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ William Eugene Wolford, Jr. Mary Josephine Selser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. 203 permit, Page 1 and 2 sh Department of Health a Important: If item 27 is 1730 Edgewood Hill Circle Hagerstown, MD 21740 William E. Wolford, Jr. - Father 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State injury Greenlawn Mem. Park 06-14-2011 4 Donation 5 Other (Specify Williamsport, Maryland 21. Signature of Funeral Sovice 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport,MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsi Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No Yes 2 Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 N မ 1 Depatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2060396 6/8/11 1126 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARID 21740 MURSHED am Hagenstown

Registrar DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital

32. Pegistrar's Signature

11-04330 Richard Wines

Please Type or Print in Black Indelible Ink. Ensure All Co	opies Are Legible	•	
State of Maryland / Department of Health and Menta Certificate of Death	al Hygiene Reg. No.	20:	1986
Name (First, Middle,Lest)	2. Date of Death		3. Time of Death

		1- For State Registrar	Cer	tificate of	Death		Re	eg. No.	13000
Physicia Nedical Exami			d Edward				2. Date of Deat Month June 9, 20	Day Year 011	1101 hrs
		 Facility Name (if not institution, give street and 1400 S. Philadelphia Boulevard, #1 	,	4	b. City, Town, or Le Aberdeen	ocation of Death		4c. County of Harford	Death
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Bir	th (MM/DD/YYYY)	Birthplace (State or Foreign
Director		220-52-5511 1XM 2	61	Yrs.	Months Days	Hours Min.	12/09	7/1949	Country) NJ
any .		Usual Residence of Decedent 10a, State 10b, County	10c City	Town or Location	าก				10d. Inside City Limits
	Þ	MD Harford	, red. only,	rown or Loodin		deen			1 X Yes 2 No
Maryl. 28a-f	Director	10e. Street and Number	•		10f. Zip Code		11	0g. Citizen of Wha	at Country?
ith the Maryland 23a or 28a-f sho notified at ooce	ā	1400 S. Philadelp			2100	1		U	.S.A.
tems ;	nera		Decedent Ever in U.S I Forces?		Decedent of Hispa es, specify Cuban, I			- 14. Race - White,	- American Indian, Black, , etc.
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shematic event, the Melical Examiner must be notified at once	Fu	1 X Ye 3 Widowed 4 X Divorced If Yes, Give or Dates:	s 2 No	71 1	Yes 2 X No	specify:		Specify:	White
ours af	d by	or Dates:	rade completed)	16a. Decedent	's Usual Occupatio	n (Give kind of wo		16b. Kind of Bus	
6 72 hc	Completed	Elementary/Secondary (0-12) College	e (1-4 or 5+)	during mo	st of working life. [OO NOT use retire	d)		
within iene.	Ĕ	11			_ Disab			<u> </u>	
filed I Hyg	Bec	17. Father's Name (First, Middle, Last)			18	B.Mother's Name (
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	10 B	James William Wind 19a. Informant's Name/Relationship (Type, Print)	es	19b, Mailing	Address (Street:			Leveri	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na injury or other traumatic event, the Medical Ex		Megan M. Wines / D	aughter		•				PA 17403
Fe I and Filters or tra		20a. Method of Disposition 1 Burial 2 X Cremation 3 X Remova	20b. P	Nana of Diagoni	lion /Name of some		Dete	20c. Location -	City or Town, State
Pages nent of		4 Donation 5 Other Specify:	Cre	mation	er place) Direct Se	ervice 20	11	York,	PA 17401
Baltimore, permit. Pages I at Department of Hee Important: If ite		21. Signature of Fune al Service Licensee		22. N	ame and Address o	of Facility J.J	. Harte	nstein M	lortuary, Inc.
		23a. Part I. Enter the disease, or complications that	at any and the death	1	9 S. Mai	n St.,	Stewart	tstown, 1	PA 17363
Physician /Medical		failure. List only one cause on each line,							rt Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Hyper Due to (or a	tensive A	therosc	lerotic (Cardiova	scular	Disease	Deau
		Sequentially list conditions, b.							
	iner	if any, leading to immediate Due to (or a cause. Enter Underlying Cause	s a consequence of	Or .					
i ii	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or a	s a consequence of	·):					_
5 7 8		d							
	n/Medical		D23a,27,p		917 7-7-1	1 sm			()
8760, tificate be ng physicias the buri	3	23b. Was decedent pregnant in the	es, outcome of pregr e birth		al death 3	Ectopic pregnan	су	23d. Date of o	delivery Day Year
Box 68 e death certi the attendin ed for use a	sicia	1 Vos. 3 No. 9 Helicour	egnant at time of dea	oth	er (Specify)				
hat the death certified by the attending detached for use as it	Physicia	9 01	known g to death but not re	esulting in the ur	nderlying cause giv	ren in Part I	23e Did to	phacco use contrib	oute to the cause of death?
P.O.	2	Silinguin	g to double but not re	outing in the di	idenying cause giv	of in Fact.			Probably 4 Unknown
requir	etec	- 100 51					24a. Was		Vere autopsy findings available
e law te has ge 2 st	Completed			-			autop	rmed? de	nor to completion of cause of eath?
of Vital Records, ng Physician: The law require. The taken selloner this certificate has been sineral director, page 2 should b		25. Was case referred to medical		-	26.Place o	f Death (Check or	1 ✓ Yes niy one)	2 NO 1	Yes 2 No
Vita hysicia this co	To Be	examiner? 1 Yes 2 No Hospital: 1	Inpatient 2	ER/Outpatient	3 DOA	ther4 Nursing	Home 5	Residence 6	Other: Scene
Ing P			ate of Injury onth, Day,Year)	28b. Time of In			8d. Describe I	how injury occurre	d
ivisior or Attendather death Director:	catic	2 Accident Investigation				s 2 No			
Division pital or Attendit ours after death. oral Director: A	Certification:	4 Homicide determined (Speci	lace of Injury - At ho fy)	ome, farm, stree	t, factory, office bui	iding, etc. 2	or Town, S		er or Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Fuseral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical C	29a. Certifier 1 Certifying Physician: To the long one) 2 Medical Examiner: On the base and manner	is of examination ar	ge, death occum nd/or investigati	ed at the time, date on, in my opinion, o	and place, and death occurred at	ue to the caus	se(s) end manner and place, and du	as stated. ue to the cause(s)
	Ž	29b. Signature and title of certifier			29c. License				d (Month, Day, Year)
		レーベレー			O.C.M	.E.		June 10, 20	∤11
		30. Name and address of person who completed c Donna M. Vincenti, MD Assistan	ause of death (Item t Medical Exam		W. Baltimore S	Street, Baltimo	ore, MD 21	223	
St Regist	ate rar	31. Date filed (Morth, Day, Year)	Registrar's Signatu	re, L	K)				
DHMH 17 Rev 1/20		JUN 2 () 2011 /	bour 1	ORIGINAL					
00145 0000		601.0		SINGHAL	-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June June 10 Day 2011 Physician/ 1530 Рм Hilda Elizabeth Whalen Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Ceci1 E1kton Union Hospital Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Social Security Number 7. Age (In yrs. last birthday) **Funeral** OCT 19 Day, Year 30 covirginia Months Days Hours 1 □ M 2 🗓 F 80 Director 218-26-4838 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State with the Maryland Director 1 Yes 2 X No E1kton Maryland Ceci1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral United States 21921 130 Knollwood Road hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian . Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces 1 ☐ Yes 2 X No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: should be filed within 72 hours aften and Mental Hygiene. 7 is marked other than "natural", White 3 X Widowed 4 □ Divorced Completed Year or Dates 16a Decedent's Usual Occupation 16b Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Telephone Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Florence E. Hudson John D. Mason injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 130 Knollwood Road, Elkton, MD Cindy W. Lent/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 16 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union, MD Union Cemetery 2011 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signative of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD Approximate Interval Between 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician NEUMON Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list or citions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) CCIDEN burial-tran ŵ attending physician for use as the burial Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 - Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f 9 Unknown g Unknown Hospital or Attending Physician: The law requires that the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Munknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 🗌 Yes After this certificate Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? 2 No Other: 10 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury (Month, Day, work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Could not be after death Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe

Registrar
DHMH 17 Rev 7/2009

State

1500

1000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G916 6/29/2011 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) White Iton R. **Physician** 6:58AM une 1105 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Prince George's Hospital Center Cheverly If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Yrs. Sept. 29, 1937 North Carolina 73 **Director** 241-62-5914 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f show notified at 1 XYes 2 No Director District Heights Maryland Prince George's the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t r than "natural", or items 23a or the Medical Examiner must be r United States 20747 7201 Fairfield Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examines once. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 African Specify. Specify þ 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Account Executive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Estella Dildy ည Rhuby White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 Dorothy J. White - Wife 7201 Fairfield Court District Heights, Md. 20b. Place of Disposition (Name of cemetery crematory or other place)

Mary Land Date 20c. Location - City or Town, State 20a. Method of Disposition June -6**17** 2011 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Veterans Cemetery Cheltenham, Maryland 21. Signature of Fungial Service License 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final END Stage Parlanson **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Preumonia Horication 1 ☐ Yes 2 No 3 Probably 4 X Unknown Completed DIAbete Mellitus 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1 Yes 2 X No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA P 1 Inpatient s after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I

completely filled Filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the

State Registrar

Doro 31. Date filed (Month, Day Year) JUN 0 7 2011

30. Name and address of person

29b. Signature

who completed cause of death (Item 23a) (Type, Print) Are Ste 203 Bult nure, MUZIZOG 32. Registrar's Signature

29c. License number

D0053337

29d. Date signed (Month, Day, Year)

2011

Francis Young 11-03920 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK UNK State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 25, 2011 1500 hrs Medical Examiner OUN trancis 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkin Bayview Medical Center Baltimore 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Months Days Min. Hours Director 212-56-1551 Country) 1 M 2 F Junel Maryland Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location and Menial Hygiene. 77 is marked other than "natural", or items 23a or 28a-f show natic event, the Medical Examiner must be notified at once. 1 Yes 2 No timore 10e. Street and Number 10g. Citizen of What Country KNOWN Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S.] No 1972 Armed Forces? 1 Never Married 2 Married 1 Yes Specify: Black 1 Yes 2 No specify. 4 Divorced If Yes, Give Yeer 2 Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene. 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 NKNOWN UNKNOWN 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) Elizabeth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 is n Road Baltimore, MD. Leith 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Paradise (emetery 4 Donation 5 Other Specify. 22. Name and Address of acility 21. Signature of Funeral Service Licensee Home, P.A. ton St. Cambridge, MD. 21613 Henry Funeral Hon lle P. it I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in **Physician** Between Onset and failure. List only one cause on each line /Medical a. Neck Injury Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and ransit Physician/Medical certificate has been signed by the attending physician sector, page 2 should be detached for use as the burial UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Other Nursing Home 5 Residence 6 Other Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 DOA this 1 Yes 2 No 28a. Date of Injury FOUND: Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Subject fell Natural FOUND: 1 Yes 2 ✔ No death. Director: d in by the f Pending May 25, 2011 1458 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City within 24 hours after To the Funeral Dire 3 Suicide Could not be or Town, State) 5700 Cedonia Avenue , Baltimore , MD Homicide determined (Specify) Local Street 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. May 26, 2011 Vou 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 19869 State of Maryland / Department of Health and Mental Hygiene 2 State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 201 7.20 PM NANetta Appetito une 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Glen BURNIE ANNE ARUNDEL Baltimore Washington Medical Center Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 1 □ M 2 😿 F 178 26 0960 78 02/26/1933 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Baltimore 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? U.S. 21225 521 Cresswell Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Yes 2 X No Yes, Give 1 Yes 2 X No Specify: White Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 9th College (1-4 or 5+) MD Motor Vehicles Records Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Whoolery Violet McManus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Cheek / son Glen Burnie, Maryland 21061 7527 Jacqwill Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MD State Veteran Cem. 06/20/2011 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signatore of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease of complications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Onset and Death Immediate Cause (Final Multi-ORGAN FAI LURE disease or condition resulting in death) Due to (or as a consequence of): Bacteria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of: that initiated events Due to (or as a consequence of): resulting in death) Last

₽nysician/ Medical **Examiner** physician and the burial-transi Division of Vital Records, P.O. Box 68760

Exami

Completed by Physician/Medical

Be 2

Certificate:

(Check only one)

29b. Signature and title of certifier

Physician/

Medical

10a. State

Director

Funeral

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Completed

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Examiner

Funeral

Director

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at

NANE

Baltimore, Maryland 21215-0036

e Hospital or Attending Physician: The 1 124 hours after death. e Funeral Director: After this certificate h

	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
1	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Diabetes		1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed? 1 ☐ Yes 2 ♣No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death (Check	only one)
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon	ne 5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury work? on M 1 □ Yes 2 □ No	8d. Describe how injury occurred
3 Suicide 6 Could not 4 Homicide determined		8f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Physics	ysician: To the best of my knowledge, death occured at the time, date and place, and	due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

14,2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 1 = For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Willie 0. Alderman 201 5:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death ecil Doint VA MARYLAND HEALTH CARE SYSTEM Perry . Social Security Number If Under 24 Hrs. If Under 1 Year **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign NC Country) Days Min. 1 **X** M 2 □ F Hours 244-22-0826 12/05/1924 86 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 🔀 Yes 2 🗆 No MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21201 11 South Eutaw Street USA 11. Marital Status Unk Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 2 □ No 1943 1 X Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 1946 Specify: Black Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Industry Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Tate Alderman Annie Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Nelson - sister 1015 Bennett Place, Baltimore, MD 21223 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board, 6
Baltimore Street, Baltimore, MD 21201 21. Signature of Funeral Service Licensee Ronald S. Wade, Director per 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 200 2+44c disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to impedate cause. Enter Underlying Examine attending physician and for use as the bunial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 🗌 Yes 2 No ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? ţë: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: Joythe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) MAY 30,201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -7 Karithanom V M. D. VA MOW LAND HE AUTH

State Registrar

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derman,

physician;

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month June Physician/ 20T1 Rakshpal Singh Aggarwal 22:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Howard County General Hospital Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea March 13, 9. Birthplace (State or Foreign Country) India Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 74 **Director** 054-48-5811 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location at 10a. State with the Maryland Director Examiner must be notified 1 Yes 2 X No |Maryland Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō items 23a Funeral 21045 United States 8736 Warm Waves Way · death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. ō þ 1 Never Married 2 X Married Maryland 21215-0036 Specify: Asian Indian 1 ☐ Yes 2 🔀 No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Planning Commission Master Urban Planner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be Department of Health and Menta. Important: If item 27 is marked any injury or cat. မ Lakshmi Chand Shanti Arya 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7865 Maple Lawn Boulevard, Fulton, Maryland 20759 Anju Aggarwal Bennett Kilduff/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 20, 1 Burial 2 Cremation 3 Removal from State West Arundel Crematory 2011 Odenton, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 21. Signature of Funeral Service Licenses M01386 ARE complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or shock, or heart failure. List o Approximate Interval Between Onset and Death Hours Immediate Cause (Final Physician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 10 Years Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and -tran Due to (or as a consequence of) resulting in death) Last g physician and the burial-t Physician/Medical Box 68760 nding p IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for us in the past 12 months? Month 5 Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown the P.O. | signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Ischemic Cardiomyopathy Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has perform death? 1 Yes 2 No certificate 2 K No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🔀 No 1 Yes 1 Inpatient 2 X ER/Outpatient 3 IDOA ည within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 28d. Describe how injury occurred Certificate: iniury 5 Pending 1 X Natural 2 No Investigation Accident Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and till 29c. License number 29d. Date signed (Month, Day, Year) June 17, 2011 D65567 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, Maryland 21224 Peter V. Johnston, . Registrar's Signa State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] | | 19872 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ARNOLD JUNE 06:46 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harbor Beltimore Hospital 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min 087401 Country) 69 216-38-7156 MD **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Glen Burnie Director Anne Arundel 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 21061 USA 7102 Baltimore Annapolis Blvd 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. ģ 1 Never Married 2 Married Yes 2X No 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 X Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Mechanic Auto Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental Fis marked of Donald A. Arnold Edna M. Beach ge 1 and 2 should be nt of Health and Men t: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print)
Betty M. Eline Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Nann Ave Brooklyn Park MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crem 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 06/16/11 Glen Burnie MD 4 Donation 5 Other (Specify) uneral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv nony ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line cencer with Pleural netastatis Immediate Cause (Final Physician/ luni disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Moliguant Penicardial The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day signed by the a 1 Yes 2 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed. 2 No Yes 2 No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Impatient 2 ER/Outpatient 3 this To the Hospita: ...
within 24 hours after death.
To the Funeral Director: After thi
----leted filled in by the funeral funeral 27, Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES 001 06/14/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S Hanour St, Beltimore, MD 2122S Valeuruele I 31. Date filed (Month, Day, Year State 2 2 2011 Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Michael Joseph Bernadyn Sr Day 2011 June 16, 8:47 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5150 Wright Avenue Baltimore Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 217-34-8621 1 🔀M 2 🗆 F Days Hours Min 1170671938 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5150 Wright Avenue 21205 USA hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc 1 Yes 2 No If Yes, Give <u>م</u> 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White "natural", Specify: 3 Divorced 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 painter Commercial Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Edith Reynolds Michael M. Bernadyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 5150 Wright Ave., Baltimore, MD 21205 Patricia A. Bernadyn/Wife 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crem. 16/21/2011 Woodbine, MD ge of Funeral Service Licens por ota Marshall 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Finel Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year g 🗌 Unknown g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HODGKINS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 1 □ Yes 2 🔀 No this certificate ! Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2X No Other: မှ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) 227 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20/ 11:05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** If Under 24 Hrs Months Min Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral items ; 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ō þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No "natural", Specify: Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) th and Mental Hygiene.
27 is marked other than traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) eacher Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Brown String Field 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 0-24-2011 4 Donation 5 Other (Specify) rounsville, Signature of Funeral Service Licensee March 1101 E. North 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner RURTENSI Sequentially list conditions, if any leading a immediate Physician/Medical Examiner Due to a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 4 9 Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 25. Was case referred to medic I examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital ြု Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify, 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred V Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only of 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur 29d. Date signed (Mpnth, Day, Year) 30. Name and ad ess of person who completed cause of death (Item 23a) (Type, Print) State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [6] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bellucci Patricia Frances Physician/ Month Day 11:45PM June 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice of Queen Annes Queen Anne's Centerville 7. Age (In yrs. last birthday) 53 yrs Security Number **Funeral** 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 217-74-4628 Days 1 M 2 7 F Months Hours 1 0 / 1 0 / 1 9 5 7 b D Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If firem 27 is marked other than "natural" per increase any injury or other traumatic. 10b. County 10a. State 10d. Inside City Limits Directo Queen Anne's MD Chester 1 🕅 Yes 2 🗌 No 10f. Zip Code 21619 10g. Citizen of What Country? 1820 St. Mary's Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2X Married Completed by 1 Yes If Yes, Give 2 X No SpecWhite 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Clothing Be 17. Father's Name (First, Middle, Last)
William Pickett 18. Mother's Name (First, Middle, Maiden Surname)
Willard Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1820 St. Mary's Road, Chester, MD 21619 Louie F. Bellucci/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crem. Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 6/22/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services of Funeral Service LicenseDorota Marshall <u>PO Box 1413,</u> Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ METAGRATIC disease or condition 24-7 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? signed by the atte Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?
Yes 2 X No 2 🗆 No 1 Yes Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ Mo Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 4 ☐ Nursing Home 5 ☐ Residence 6 ♣ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cartifier 29c. License number ddress of person who completed cause of death (Item 23a) (Type, Print) 2/617 TEFFRE 2540 32. Regisfrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 28a,b, per dr., g916,06/22/2011dhb 19876 For State

		Registrar		. , . , 1		Cer	tificate of L	<i>Déath</i>			Reg. No.		
Physicia	n/	Decedent's Name (First, Middle								2. Date of De Month	ath Day	Year	3. Time of Death
Medic	al	Sophia Genev		Bailey						June	08	2011	1:15P M
Examin	er	4a. Facility Name (if not institution					4b. City, Town, or		of Death			ounty of Death	
Funeral		Anne Arundel M. 5. Social Security Number	6. Sex	7. Age	(In yrs. las	t birthday)	Annapolis Anne Anne If Under 1 Year If Under 24 Hrs. 8, Date of Birth						place (State or Foreign
Director		169-22-2505	1 □ M 2,	X F	82	Yrs.	Months Days	Hours	Min.	(Month, Da		Cour	ntry) isvlvania
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eath v tems er mu	Funeral	11. Marital Status	12. Was	Decedent Ev	er in U.S.	13. V	/as Decedent of Hi	spanic Or	igin? (Spe	cify Yes or No-		Race - Americ	can Indian,
ffter d	by	1 Never Married 2 K Mar	ried 1 _	ed Forces? Yes 2 🔀 Nes, Give	10	- 1	Yes, specify Cuba ☐ Yes 2 🛛 No			Hican, etc.)		Black, White,	etc.
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inimportant if fire X7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations					g Address (Street a						Code)
and 2 Healt tem 2	1	George Bailey 20a. Method of Disposition	/ Spou	se	20b Pla		Bay Drive	s, St		SVIIIe,		1666 tion - City or To	own State
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ding F h. After funer	Certificate:	27. Manner of Death Natural 5 Pendin	g	Date of injury (Month, Day,	Year)	8b. Time of injury	28c. Injury work	?		8d. Describe h	ow injury oc	curred	
Attender deat ctor.	ij	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be	-	/ - At home	e. farm. stre	et, factory, office	Yes 2	-	28f Location (S	treet and Nu	imber or Rural	Route Number,
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check 2 Medical E	Physician: To	the best of m	y knowled	ige, death or	ocured at the time,	date and	place, and	due to the car	use(s) and m	anner as state	d. use(s) and manner stated.
the H the F the F	Me	only one) 3 L Certifying	Nurse Practic	oner: To the be	est of my k	nowledge, de	eath occurred at the	time, date	and place	e, and due to the	e cause(s) an	d manner as st	ated.
5 ₩ 6 ©		29b. Signature and title Descrition	111	7//	$\overline{}$		29c. License		Λ -			gned (Month,	
		30. Name and address of person v	vho completed	cause of doo	oth (Item 2)	Sa) (Type P	int) 2007	060	72	Dawler	SUN	120,	2011
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State	•	31. Date filed (Month; Day, Year)	0044	32. legistrar	s Signatur	-		V-110	- y - 1/1127	20101			
Registra	r	JUN 2 2	2011	Drews	ام ر	. 190	well						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Inc 201 Tea Cecelia Bowman 1300 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Northwest Hospital Baltimore Randallstown Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days 8 (Month Bays Year) 1 □ M 2 🖫 F 216-42-7935 65 Director MD Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Randallstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3801 Schnaper Drive, Apt. 307 211.33 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African-American 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 X Divorced Year or Dates. injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Supervisor Dept. Of SocialServices Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norman Richmond Edith Snowden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Kenneth R. Vines/Son 3801 Schnaper Drive, Apt. 307, Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Druid Ridge Cemetery 6-17-2011 Pikesville, Maryland 4 Donation 5 Donation 22. Name and Address of Facility Wile Funeral Home F.A. of Baltimore Co. 9200 Liberty Road, Randallstown, Md 211.33 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year Day signed by the a d be detached f 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by VER CIRRITUSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HOLOME PENGEFAILINE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PUMONANY HYPERTEN SION performed 1 Tyes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☐ No မ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 1154288 (Item 23a) (Type, Print)
RANGARAMN NORTHUET; HOSPIMZ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) La mas wany

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year, UN 2 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ in e Medical 4a. Facility Name (if not institution, dive street and number) 4c. County of Death
Baltimore Examiner 4b. City, Town, or Location of Death Seasons Hospice Randallstown 6. Sex 7. Age (In yrs. last birthday, 54 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 1 XM 2 - F Director 214-70-7551 28a-f show 10a, State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD. Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 2901 Poplar Terrace 21216 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: African-American Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 should be filed with h and Mental Hygien. 7 is marked other th 12th Meat Outter Esskav Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leon Roland Booze Sr. Elizabeth Reid other traumatic 19a. Informant's Name/Relationship (Type, Print)
Desire Booze/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or any 2901 Poplar Terrace Baltimore, MD 21216 Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State King Memorial Park 6-11-2011 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign In 2 of Emeral Service 22. Name and Address of Facility Ville Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ AUMA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events CERTIFICATION APPROVED BY MEDICAL EXAMINES Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ☐ Pregnant at time of death☐ Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? this certificate 2 No Yes or Attending Physician: 25. Was case referred to medical Be director 26. Place of Death (Check only one) examiner? 2 No 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other 27. Manner of Death 28a. Date of injury (Month) Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After t Natural 5 Pending 1 Yes 2 Accident 3 Suicide within 24 hours after death

To the Funeral Director: /
completed filled in by the f Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide BALT Medical Certifying Physician: To the best of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State Registrar

11-0454	14
Brenda	Branham

Please 7	Type or Print in Black Indelible Ink. Ensure All C State of Maryland / Department of Health and Ment	opies Are Legible. 2	011	19879
•	Certificate of Death	Reg. No.		
nt's Name (First, I	Middle, Last)	2. Date of Death		3. Time of Death

		1- For State Certificate of Death Reg. No.														
Physici edical Exami								2	2. Date of Dea Month June 17, 2	th Day			3. Time of Death 1250 hrs			
		4a. Facility Name (if not ins 335 E. 31st Stree	itution, give str		umber)		4b	. City, Tow Baltimo		ocation of	Death		4	c. County o	f Death	
Funeral		5. Social Security Number	6. Sex		7. Age (In yrs. I	last birthda	ay)	If Under 1	_	If Under		8. Date of Bir	th(MN	A/DD/YYYY		hplace (State or
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Marylz 28a-f d at o	Director	10e. Street end Number						10f. Zip Co	de			1	0g. Ci	tizen of Wh	at Cour	ntry?
th the 23s or	io i	335 E. 31st						212						.S.A.		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoulingry or other tranmatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2		Armed F	cedent Ever in U orces? 2 X No	J.S. 13		Decedent on s, specify C				cify Yes or No lican, etc.)	-	14. Race White		can Indian, Black,
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altin mit. P partme portar ury or		4 X Donation 5 Oth 21. Signature of Funeral Se			AI k	atany (ne and Add		f Facility		<u>2/2011</u> atomy (Maryland trv
		501	#				<u>752:</u>	2 Con	nel	ley [r.,	Ste. 1	Ρ,	Hanov	er,	MD 21076
Physician /Medical		23a, Part I. Enter the disease failure, List only one of	ause on each li	ne.											rt	Approximate Interval Between Onset and Death
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Division of Vital Records, tal or Attending Physician: The law require rs after death. al Director: After this certificate has been sight in by the funeral director, page 2 should b	Completed											24a. Was a				opsy findings available ompletion of cause of
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Division septical or Attenct hours after death necral Director:	Certification:	2 Accident 3 Suicide 6 X	Could not be		e of Injury - At ho				ce buil	ding, etc.			Street	and Number	or Rur	al Route Number, City
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Division To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only	Examiner: On	the basis	it of my knowledo of examination a											
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	ate	Russell Alexander 31. Date filed (Month, Day,)			ledical Exam			. baitim	ore S	reet, B	aitimo	re, MD 212	223			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 18 201 Tea 1253 Frank Bury Jr. Ам Joseph Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Millersville Anne Arundel 8361 Elvaton Road 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Country)MD Days 1 X M 2 □ F Months Hours 1-(6-17,930 Year) 217-26-4436 **Director** Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Anne Arundel Millersville 1 ☐ Yes 2 🛛 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ntal Hygiene. 3d other than "natural", or items 23a or event, the Medical Examiner must be I Funeral 21108 USA 8361 Elvaton Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces Black White, etc. 1 Never Married 2 X Married ģ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Specify: white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Air Conditioning Welder permit. Page 1 and 2 should be filed wit. Department of Health and Mental Hygier Important: If item 27 is marked other 1 any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Mary Rose Julius Joseph Frank Bury Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genevieve Bury / wife 8361 Elvaton Rd., Millersville MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Glen Haven Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Sther (Specify) 6/21/2011 Glen Burnie, MD Signature of Funeral Service License 22. Name and Address of Facility Kirkley-Ruddick Funeral Home M01364 421 Crain Hwy SE Glen Burnie MD 21061 allas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause op each line. Approximate lewitz Pardio Vasculas Onset and Death Immediate Cause (Final Phonocian/ disease or condition Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 No the 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 Yes Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 1 No Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \blacksquare Residence 6 \square Other (Specify) 24 hours after death.

Funeral Director, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred injury 1 Natural 5 Pendina 2 Accident
3 Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 6 20 11 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pasadoro muzila Rd Christopher 31. Date filed (Month, Day, Year) 3708 mountain m.D.

Registrar

11-04522 Leonard Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 9881

		1- For State Registrar			,		Certi	ificate	of L	Death				3	Reg. N	o.		
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Funera Directo			8-9459	6. Sex	4 2 F		(In yrs. last birthday) 48 Yrs. If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (SI Foreign Country) 1.							n .				
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Division Bospital or Atteo A hours after death Fueers Director:	Certification:	3 Suicide	dete	d not be rmined	(Specify)	e of Injury	- At hom	ne, farm, st	treet, 1	factory, offi	ce bu	uilding, etc	s. 2	28f. Location or Town,		and Numbe	er or Rur	al Route Number, City
Division To the Hospital or Atteotwithin 24 hours after death Within Prote Fuceral Director:	Medical	29a. Certifier 1 (Check only one) 2	Certifying P Medical Exa	miner: Oi ar		of examina				n, in my opi	nion,	death occ			e and p	lace, and di	ue to the	cause(s)
	2	29b. Signature	and title of certific	eyha	y, m	1)					.C.M	number 1.E.				. Date signe ne 17, 20		th, Day, Year)
٧		Pamela I	dokess of persor E. Southall, N		ssistant I	Medical	Exam	,	00 V	V. Baltim	ore	Street,	Baltim	nore, MD	21223	3		
Regi	State stra		nonth, Day, Year)	11	SZ. Re	gistrar's S	1 d	back	1									
DHMH 17 Rev 1	/2001		1 1	7				ORIGIN	IAL							OCME		

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				State Registrar				Cer	tificate of	Death		Reg. N	o.	
		Physicia Medi		1. Decedent's Name (a Barbara		t Conners	·				2. Date of D Month June		20, 2011	3. Time of Death 7:25 P.M
ŧ	A.	Examir		4a. Facility Name (if no Stella M	laris	street and number)				onium		40	c. County of Death Baltimore	9
	L	Funeral Director		5. Social Security Num 196-18-68 Usual Residence of De	333	ex 7. A	ge (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days		in. 8. Date of E (Month, L Sept.	Sirth Day, Year) 15,	9. Birthpl Count 1924 Cali	lace (State or Foreign ry) fornia
		Maryland :8a-f show tified at	Director		10b. County Baltimo	ore	10c. City	Cato	cation nsville			· ·	10	0d. Inside City Limits
		s 23a or 2 nust be no	Funeral Di	10e. Street and Numb					10f. Zip Code 212	28		10g. C	itizen of What Count	try?
	9800	perriit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Detartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 [12. Was Decedent Armed Forces' 1 X Yes 2 ☐ If Yes, Give Year or Dates.	?	l l	Vas Decedent of I Yes, specify Cub	an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	o-	14. Race - America Black, White, e Specify: Whit	tc.
1.	Maryland 21215-0036	within 72 hor giene. er than "nat , the Medica	Completed		15. Decedent's E fy only highest gra day (0-12)		5+)	(Give I	ent's Usual Occu kind of work done O NOT use retired Homema	during most of (working	16b. k	Kind of Business Ind	ustry
5 P.M	yland	ld be filed Mental Hyg arked oth atic event	To Be	17. Father's Name (Fir. William	, , ,	walt				1	Name (First, Middle r1 E. Tu		Surname)	
7:25	e, Mar	and 2 shou lealth and im 27 is m her traum		19a. Informant's Name	onners	pe, Print) Daughte:		432 1	Neepier		Rural Route Numb	le, M		
	Baltimore,	t. Page 1 a rtment of h rtant: If ite ijury or ott		4 Donation 5	Cremation 3 Other (Specif	T 1	e Ce	metery, crem ington	sition (Name of natory or other pla Nations	1 10	Date 0/19/2011	Arli	ocation - City or Tov	A
	Bal	Der ar Der ar Impor any ir		21. Signature of Funer	' //// \/	Mul	alce	7 22 F1	Name and Addre Ineral H 530 Edmo	ess of Facility ome of I ndson A	Sterling Catonsvi venue: Ca	Asht lle, atons	on Schwah Inc sville, MI) Witzke) 21228
		hysician/ Medical		23a. Part 1. Enter the shock, or heart fi Immediate Cause (Fir disease or condition resulting in death)	ailure. Lis only o	ne cause on each lir	1e.	66 o not ente	r the mode of dyli	ng, such as card	liac or respiratory a	arrest,		Approximate Interval Between Onset and Death
7	-d	Examiner	er	Sequentially list condi	itions,	b. Due to (or as								
201		icate be executed if physician and is the burial-transit	Examiner	if any, leading to immediate. Enter Underlying Cause (Disease or iing that initiated events resulting in death) Last	jury	c. Due to (or as						<u>.</u>		
3 20,	98760	ficate be e g physicia as the buri	Medical		·	d			_			_		
JUNE	_	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/N	IF FEMALE: 23b. Was decedent prein the past 12 mo 1 Yes 2 1 9 Unknown	egnant	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 🗀 Fetal at time of de	death 3	Ectopic pregnan Other (specify)	су			23d. Date of deliver Month	ry Day Year
		luires that t in signed b uld be deta	<u>م</u>	Part II. Other significa	ant conditions co	ontributing to death	but not resu	liting in the ur	nderlying cause gi	ven in Part I.	_	tobacco	use contribute to the	e cause of death?
CONNERS	Division of Vital Records,	The law rec ate has bee page 2 sho	Completed									opsy formed?	prior to com death?	sy findings available npletion of cause of
CON	/ital	rsician: s certific director,	To Be	25. Was case referred to examiner?	-	Hospital:	iant O [ER/Outpatien	Oth	lace of Death (C				
BARBARA	on of \	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s		27. Manner of Death 1 Natural 2 Accident	5 ☐ Pending Investigation	28a. Date of inju (Month, Da	ury :	28b. Time of injury	28c. Injur worl	y at	g Home 5 L Hes 28d. Describe		Other (Specify) y occurred	
BAR	Divisi	ital or Atterns after de ral Directo		3 ☐ Suicide 6 4 ☐ Homicide	6 Could not be determined	28e. Place of Inj	iury - At hor c. (Specify)	ne, farm, stre	et, factory, office			(Street an wn, State	nd Number or Rural F *)	Route Number,
		To the Hospital or within 24 hours afte Fo the Funeral Dir completed filled in	Medical	29a. Certifier 1	Medical Exami	ner: On the basis of e	examination	and/or investi	gation, in my opini	on, death occurr	ed at the time, date	and place	nd manner as stated e, and due to the caus s) and manner as stat	se(s) and manner stated
1		vitt CO		29b. Signature and title	e of certifier	eunp			29c. Licens	e number 4742		29d. Da	te signet (Month, Da	ay, Year)
3	+			30. Name and addless		RNP 2300	DULAI	VEY VA	LLEY ROA	D TIMO	NIUM, MD	2109	93	
¥		Stat Registra	· C	31. Date filed (Month, L	Day, Year)	2. Registr	ar's Signatu	far.	الما					

Registrar

MASSELINK BRIAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

29b. Signature and title of certifie

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

June 16 2011

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death Eugene Ellsworth Dailey Physician/ Day 201 T June 17, 3:00 PM Medical 4b. City, Town, or Location Towsoft 4a. Facility Name (if not institution, give street and number) **Examiner** or Location of Death Baltimore Gilchrist Hospice Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 220-54-5187 1 🕱 M 2 🗆 F Hours 60 10/10/1950 MD **Director** Yrs Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD Harford Street 1 Yes 2 X 10f. Zip Code 21154 10g. Citizen of What Country? 10e. Street and Number 929 Federal Hill Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 No Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: should be filed within 72 hours after and Mental Hygiene. Specify: White 3 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Local Government 12 Be . Eather's Name *(First, Middle, Last* Eugene Dailey 18. Mother's Name (First, Middle, Maiden Surname)
ROSE Carom 19a. Informant's Name/Relationship (Type, Print)
Michelle M. Dailey 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State Zip Code) 929 Federal Hill Rd., Street, MD 21154 / Wife permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State remetery, crematory or other place)
Final Journey Crem. 1 Burial 2X Cremation 3 Removal from State 6/22/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota, Marshall 22. Name and Address of Facility Mary Land Cremation Serv PO Box 1413, Baltimore, Services ore, MD 21203 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ rcusti disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical O Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 2 🗌 No Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 NG ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 In DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury Natural 5 Pending Accident 1 Yes 2 No Investigation within 24 hours after death To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a title of c 29c. License numbe 29d. Date signed (Month, Day, Year) MD D71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 BACTIMORE KUMAR N CHARIES

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year OZIER NRU 06 6:15/0M Medical 6 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6823 W FOREST ROAD # 101 PRINCE GEORGE'S HYATTSVILLE 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 73 Months 1 ▼M 2 □ F Days Min. **Director** AUGUST 1937 NORTH CAROLINA Yrs 238-56-9715 Usual Residence of Decedent shov or 28a-f shoven 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 ☐ No MD PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 6823 W FOREST ROAD #101 20785 USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 X Never Married 2 Married by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. BLACK 3 Widowed 4 Divorced Specify: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 9TH CONSTRUCTION WORKER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည CLAUDE DOZIER PEARLIE ALSTON injury or other traumatic 20785 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau REGINA BOWIE/DGT FOREST ROAD # 101 HYATTSVILLE, MARYLAND Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE, MARYLAND RIVERDALE CREMATORY 6/22/2011 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. 23a. Part 1 Part 1. En shock, or Interval Between Onset and Death Immediate Cause (Final Physician/ 22 disease or condition ON Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Examir -transi Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last -burial attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death bec the Unknown 9 Unknown be detach by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ed 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown should neec 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? certificate 1 ☐ Yes 2X No 1 Yes 2 X No director. 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Tes 2 No Other မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural work? 5 Pending injury M 2 🗌 No the 1 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Hospital Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date\signed (Month. Dav. Year) D 30. Name and address of person who e of death (Item 23a) (Type, Genevieve Defense Hwy. Aylor CRAP 31. Date filed (Month, Day, Year) State 2 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Diehl Edward 0150 AM Joseph June 2011 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Easton HOSIDITAL Easton aT If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. Country)
Pennsylvania Director 199-42-3680 Usual Residence of Decedent Z7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medic-I Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 - Yes 2 X No Caroline Preston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21182 Marsh Creek Rd., Lot 45 21655 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Painter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it. Page 1 and 2 should be fil trment of Health and Mental rtant: If item 27 is marked in njury or other traumatic ev 2 Theodore Diehl Marion Heisse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Diehl / Wife 21182 Marsh Creek Rd., Lot 45, Preston, MD 21655 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot once. 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 06/20/2011 | Hanover, Maryland 21. Signature Juneral Service Linnsee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardiovasculas event 19 che mic embolic Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner cardiovascular disease the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown certificate has been sirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Suicide Investigation within 24 hours after death To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) our Brother 00059487 6-19-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 219 South Washington St., #202, Easton, MD 21601 John Botsis Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 28'M DEVIN TREVOR DANIELS 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days MARYLAND N/ADirector JUNE14,2011 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director UPPER MARLBORO ANNE ARUNDEL MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 2 should be filed within 72 hours after death with and Mental Hygiene. Is marked other than "natural", or items 23a or 0705 TYRONE DRIVE 20772 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be DELONTA DANIELS JASMINE DENISE WRIGHT မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 APRIL WALTON / GRANDMOTHER 10705 TYRONE DRIVE UPPER MARLBORO, MD 20a. Method of Disposition
1 ☐ Burial 2X Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) JUNE ate permit. Pages 1
Department of H
Important: If Ite
any Injury or ot BAYVIEW CREMATORY 18,2011 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ACZOROWSKI FUNERAL HOME, PA 21. Signature of Funeral Service Lice see Lubor DUNDALK AVENUE BALTIMORE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Extreme disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760 attending physiciar Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy ģ in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 2 No 3 Probably 4 Unknown 1 TYes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 has 2 🗌 No 2**X** No 1 TYes certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 ☐ No 1 Unpatient 2 ER/Outpatient 3 DOA P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After or Attending 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Hospital

Medical

DHMH 17 Rev 1/2001

11595

State Registrar

29a. Certifier

one)

(check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) --



Amelia Jemigan Mo of person who completed cause of death (Item 23a) (Type, Print)

JUN 2 2 2011

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 36621

29d, Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Frank Edward Fuller _1 9^{Day} Physician/ June 201^{real} 2:10 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number 216-38-5037 last birthday If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. **Funeral** Country) MD 1 X M 2 □ F Months Hours 08/28/1933 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County Anne Arundel permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10d. Inside City Limits 10c. City, Town or Location Director Annapolis 1 X Yes 2 No 10g. Citizen of What Country USA 10f. Zip Code 21401 10e. Street and Number 2 Alder Road Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces 1 Yes 2 Air If Yes, Give 953-55 Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Entertainment Entrepreneur Be 17. Father's Name (First, Middle, Last)
Frank Trevitt Fuller 18. Mother's Name (First, Middle, Maiden Surname)
Ada Jacqueline ဂ္ 19a. Informant's Name/Relationship (Type, Print)
Shannon Irizarry/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 270 Eareckson Lane, Stevensville, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date remetery, crematory or other place)
Final Journey Crem. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6/24/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Dorota Marshall

22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician しとか MONTH disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ sate has been signed by the atter page 2 should be detached for in the past 12 months? Month Day Year Pregnant at time of death 2 No Yes Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 certificate 1 Tes 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after deat To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29b. Signatui 29c. Li 29d. Date signed (Month, Day, Year) 16 ath (Item 23a) (Type, Pric 31. Date filed (Month, Da 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 8:53 PM DUS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MOR OME Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 1 □ M 2 🗶 F Months Hours Country) Director 63 28a-f shov at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits must be notified MD NA Baltimore 1X Yes 2 ☐ No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2318 Koko Lane 21216 U.S.A. items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces o. þ Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes X☐ No Specify. "natural", 3 X Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 9th grade Housewife Home . Page 1 and 2 should be filed wit tment of Health and Mental Hygie tant: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Allen A. Montgomery Esther M. Speed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2318 Koko Lane, Baltimore, Md 21216 Esther Parker-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Important: If it any injury or o 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place ♠☐ Donation 5 ☐ Other (Specify) Garrison Forest 6/28/2011 Owings Mills, Md March F/H West 4300 Wabash Ave, Sunature of Funeral Service Licenses Baltimore, 23a. Part 1. Enter the disease, or complications that caused shock, or hear failure. List only one cause on each line Immediate Cause (Final weed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between set and Death Physician/ EPS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner week Sequentially list conditions, cause. Enter Underlying Examine requires that the death certificate be executed burial-transit MALNUTRITION)WKWOWA Cause (Disease or liniur) SEVERE and that initiated events resulting in death) Last physician Physician/Medical IMMUND DEPICIENCY SYNDROME KLOUL Division of Vital Records, P.O. Box 68760 use as the the attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No for Pregnant at time of death Month Day should be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available Hospital or Attending Physician: The law has page 2 prior to completion of cause of death? autopsy performe this certificate Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital 2 No 1 🗌 Yes Other: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) 24 hours after death. Funeral Director: A 1 🗌 Yes 2 \square No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERTO FERNOU DEZ DUBRIE MUDUE 12 STREET BUTIMORE Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Charles George Gamber Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ 0821 hrs Medical Examiner June 19, 2011 Charles George Gamber, III 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Owings Mills **Baltimore County** 9934 Reisterstown Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director Country) MD 1 XM 2 F 212-19-6960 29 Nov 17, 1981 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location s 23a or 28a-f show e notified at once, 1 Yes 2 X No Carrol1 Hampstead Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-5 sho 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2817 Hampstead-Mexico Road 21074 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Equipment Operator Construction 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilma Lee Kunkel

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles George Gamber, 19a. Informant's Name/Relationship (Type, Print) (Father) 818 Regent St., Westminster, MD 21157 Charles G. Gamber 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 6/24/2011 Baltimore, MD Lorraine Park Cem. 4 Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, PA HULCH 23a. Part I. Enter the disease, or conditications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician /Medical Approximate Interval failure. List only one cause on each line. Between Onset and Death a Methadone Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Pur Physician/Medical AMENDED Item# 1 as noted, 23a, pt. II, 27, 28a-f, per me, g917 tending physician a use as the burial -X UNPENDED 3-11 smRecords, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown ē 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 V Unknown Cocaine, Narcotic, and Alprazolam Use Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has performed? death? ✓ Yes 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene DOA ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Unknown 1 Yes 2 X No 5 Pending fd 6-19-11 fd 8:08 am Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide or Town, State 9934 Reisterstown Rd. Owings Mills, Md. To the Hospital or within 24 hours at To the Funeral I (Specify) Parking Lot Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) June 20, 2011 O.C.M.E. 00 ral 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

Carol Allan, MD

32. Regis ar's Si

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

O Kal

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1	For State Registrar	•	Certificate of I			g. No.				
oian		Decedent's Name (First, Middle, Last)	D 0			Date of Death Month	Day Year				
cian dical			a D. Gatt		1 1 1 1 1 1 1 1	June	19 201 4c. County of Dea				
iner	1	4a. Facility Name (If not institution, give street and number			Location of Death		Baltimore				
al		3601 Annapolis Road Apt 5. Social Security Number 6. Sex 7.	B Age (In yrs. last birtl	hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,					
r		231 11 9729 1□M 2ॼF	53 y	rs. Months Days	Hours Min.	10/26/	1957	rthplace (State or Foreign ountry) Maryland			
	- 1-	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town	or Location			10d. Inside City Limits				
ţ	5	Maryland Baltimore	Ba1t	timore				1 □Yes 2 🗷 No			
ire.		10e. Street and Number		10f. Zip Code		10	g. Citizen of What C	ountry?			
<u></u>	2	3601 Annapolis Road Apt.	В		1227		U.S.				
1		11. Marital Status 12. Was Decede Armed Force	s?	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi				
2	2	1 Never Married 2 Married 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Date		1 □Yes 2 🕱 No	Specify:		Specify:	White			
Completed by Funeral Director	2	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occup	ation during most of work	ina 1	6b. Kind of Busines	s/Industry			
a de	1	Elementary/Secondary (0-12) College (1-40	or 5+)	(Give kind of work done life. DO NOT use retired omemaker	1)		Own Hor	me			
0	3	17. Father's Name (First, Middle, Last)		Omemaker	18. Mother's Nam	e (First, Middle, M		ii C			
B	ן ב	Herbert Hyns	on, Sr.	-	G1end	a Moran					
F	-	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address (Street			City or Town, State	Zip Code)			
		Stacy Hynson / Sister		234 Wasena A			re, Maryl				
		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from Sta	20b. Place of cemeter	Disposition (Name of y, crematory or other place	ce) !	10011	0c. Location - City o				
	-	4 ☐ Donation 5 ☐ Other (Specify)	Glen H	aven Mem. Pa	alk i			e, Maryland			
ouce		21. Signature of Funeral Service Licensee	roushi	22. Name and Addre	nie Highwa	nce Funer ay Balt	al Servic	ryland 21225			
		23a. Part1. Enter the disease, or combilications that cau shock, or heart failure. List only one cause on each	sed the death. Do r	not enter the mode of dvi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death			
al		disease or condition resulting in death) Due to (or	as a consequence of	of):	1 1	1- 1\		IZMENID			
er	Sequentially liet conditions 12 me										
i.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d										
200	Yall	that initiated events c.	as a consequence of	of):							
100											
		IF FEMALE:									
l/uci	2	23b. Was decedent pregnant		23d. Date of o Month	delivery Day Year						
i o	Completed by Prhysician/iv	1 Yes 2 No 4 Pregnal 9 Unknown 9 Unknown	nt at time of death	5 ☐ Other (specify) _			World Day Tour				
1	2	Part II. Other significant conditions contributing to deat	h but not resulting ir	n the underlying cause gi	ven in Part 1.	23e. Did tob	acco use contribute	to the cause of death?			
3			<u> </u>			1 □ Ye	s 2 No 3	Probably 4 Unknown			
200	blei					24a. Was ar autops	y prior	autopsy findings available to completion of cause of			
2	5					perform 1 🗆 Yes 2	ned? death No 1 □ Y	es 2□No			
á	a De	25. Was case referred to medical examiner?		Ot!	ner:	th (Check only one					
F	2	27. Manner of Death 28a. Date of	natient 2 ER/Ou	Time of 28c. Inju	ry at		ence 6 Other (S w injury occurred	pecify)			
		1 ☑ Natural 5 ☐ Pending (Month, 2 ☐ Accident investigation	Day, Year)	Injury Wo	rk?]Yes 2□No						
1	Medical Certification: 10	3 ☐ Suicide 6 ☐ Could not be 28e. Place of	Injury - At home, fa , etc. <i>(Specify)</i>	ırm, street, factory, office		28f. Location (St. City or Town	reet and Number or n, State)	Rural Route Number,			
3	ا دو ا	29a. Certifier 1 Certifying Physician: To the b	est of my knowledge	e, death occurred at the	time, date and place	e, and due to the c	ause(s) and manne	r as stated.			
100	ealc	(Check only one) 2 Medical Examiner: On the base and manne	is of examination ar	nd/or investigation, in my	opinion, death occi	irred at the time, d	ate and place, and o	due to the cause(s)			
2	Σ	29b. Signature and title of certifier		29c. Licen	se number		9d. Date signed (Me	onth, Day, Year)			
		7500	of death (the co.)	(Time Dried)	1570		June	201			
		30. Name and address of person who completed cause	or death (Item 23a)	(Type, Print) 30	015	Hano	ore or	D 21225			
State	е	31. Date filed (Month, Day, Year) 32. Re	ictrar's Signature								
stra	r	IIIN 2 2 2011 1	and A	Marke							

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death, Physician/ Month EVELYN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster Carroll Hospital Center 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 21 9. Birthplace (State or Foreign Country) **Funeral** Days Min Months Hours 219-20-1481 85 Yrs **Director** 1925 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MD Westminster Carroll 1 ☐ Yes 2 🗶 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertal Hygiene. Important; I ferm 27 is amarked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be Funeral 21158 USA 936 Stone Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Deceuen. _ Armed Forces? □ Yes 2**X** No 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2X Married Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own Home 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Florence Matilda Stone William Andrew Manning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 936 Stone Road, Westminster, MD 21158 William Grimes/spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, 22. Name and Address of Facility State Anatomy Board, Signature of Funeral Service Licensee Ronald S. Wade, Director per DVR Baltimore Street, Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician, OSTRIDIUM disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? ☐ Ectopic pregnancy ☐ Other (specify) ____ 4 Pregnant 9 Unknown Pregnant at time of death Month Day Year the 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) iniury 1 / Natural 5 Pending 2 Accident Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WEST MINSTER MD 21157

GALVIN

291

32. Registrar's Signature

Senera B. Janes

STONER

State Registrar HOMAS

31. Date filed (Month, Day, Year)

JUN 2 2 201

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#19a, perFH, G917, //14/2011, WS

State of Maryland / Department of Health and Mental Hygien [For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6 3. Time of Death Day 19 Physician/ Bonita L Gorski ร:3เ 201 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Woryland Medical Baltimore Center 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛭 F 212-44-2502 Director 66 MD Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director MD Anne Arundel Glen Burnie 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 USA 1315 Gatwick Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white If Yes, Give Specify Completed 3 Widowed 4 Divorced Year or Dates ed other than "natur event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Home maker is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bernard Leslie Dixon Florence Louise Disney 10a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Robert T. Gorski/husband 1315 Gatwick Rd., Glen Burnie MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nichols Bethel Cemetery 6/24/11 Odenton, MD 21. Signatum 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy SE Glen Burnie MD 21061 M01364 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impary Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No for Month " Dav Pregnant at time of death Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ this certificate has been signeral director, page 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 2 🗆 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending s after death.

I Director: Aff Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 187181833G 6/19/2011 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Greene St. Jaffe 22 ecor Baltimare, MD 31. Date filed (Month. Day. State JUN 2 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:07 am TIME Medical 4a. Facility Name (if not institution, give street and numb Examiner 4b. City, Town, or Location of Death 4c. County of Death HOS PI BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 ▼ M 2 □ F 406-07-2138 90 Months Days Hours MAMRO^{H, D}Y', **9°2**°1 Director KENTUCKY Usual Residence of Decedent 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits or 28a-f sl e notified MD. 1 X Yes 2 No BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe Funeral ral", or items 23a Examiner must b 3817 FOSTER AVENUE 21224 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Arroed Forces? 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes. Give "natural", 3 Widowed 4 Divorced Specify: WHITE Year or Dates event, the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. MAINTENANCE MANAGER CANTON COAL PIER Be 17. Father's Name (First, Middle, Last) (UNK) 18. Mother's Name (First, Middle, Maiden Surname) marked OWEN GRADDY ALMA LOU other traumatic and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>s</u> permit. Page 1 and 2 sh. Department of Health ar Important: If item 27 is any injury or other trau MARY GRADDY WIFE 3817 FOSTER AVENUE BALTIMORE, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of JUNE_{te} 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) 22, 2011 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY 22. Name and Address of Facility KACZOROWSKI FUNERAL HOME, PA . Signature of Funeral Service Licensee AVENUE BALTIMORE DUNDALK 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ days Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by acute Renal Foulure, coronary outery disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Congestive heart Foulure, attial Fibrillation Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 24 hours after death.

9 Funeral Director, After this certificate haleted filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{Yes} \) Certificate: To 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. RES - ou l June, 18, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hamover Street, 21225, MD

State Registrar 2 2 2011

19895 State of Maryland / Department of Health and Mental Hygien ? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Siln & ZOII Karen Hammett 3:45 A M Medical 4a. Facility Name (if not institution, give street and number)

1 Jesse Boyd Circle **Examiner** 4b. City, Town, or Location of Death Elkcon 4c. County of Death Cecil 7. Age (In yrs. last birthday) 54 yrs If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 218-52-3487 1 🗆 M 2 🔀 F Days Hours Min. Months 1 1707 7 1956 **Director** MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Elkton Cecil 1 X Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 21921 10e. Street and Number 5 r items 23a or ner must be n Funeral 1 Jesse Boyd Circle with permit. Page 1 and 2 should be filed within 72 hours after death: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify. Completed 3 Divorced 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Fiscal Clerk Local Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Doris Doering ဂ Bernard Wagener 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) r 1 Jesse Boyd Circle, Elkton, MD 21921 Gretchen Hammett/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. 6/22/2011 Woodbine, MD Signature of Funeral Service Licensee Dorota Marshall
Double W. Way Way 22. Name and Address of Facility Maryland Cremation Services PO 30x 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lung (ancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir ng physician and as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Bax 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death be detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year Pregnant at time of death g Unknown g 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 \(\sum \) No Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No 1 Natural injury ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) m skyapameM.D 6/19/11 DO057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209 5-203 ·s. Rajapakse/M·D 2835 Smith Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #26, 30 per NP g 916 6-22-11 d.o.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 15 2011 Carvel Haynes 7:21 \mathbf{P} M June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 1541 Sherwood Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Months Days Hours 219-34-135 3 Yrs Director MARUIAND Usual Residence of Decedent 28a-f show 10a. State 72 hours after death with the Maryland aţ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or than "natural", or items 23a or 28a-fs the Medical Examiner must be notified BALTIMORE 1 Yes 2 □ No IND 10e Street and Number 10g, Citizen of What Country? Funeral SHERWOOD AVENUE 21239 4.51 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: BLACK Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) UNKNOWN within 7 Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Be Le, Marylar,
Leffinit. Page 1 and 2 should be filed.
Department of Health and Merrimportant. If item 27 is any injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY E. WIFE SHERWOOD AVE., BAL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ➤ Burial 2 □ Cremation 3 □ Removal from State GARRISON OWINGS MILLS, MARYLAND 27/2011 4 ☐ Donation 5 ☐ Other (Specify) FURESTCEME C. JONES FIH, PA . Signature of Funeral Service Licensee DERRICK 22. Name and Address of Facility Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onse J d Death Immediate Cause (Final Physician/ disease or condition Dirpete Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence on or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events the burial-tran attending physician and Due to (or resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 L 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗆 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed? 2 WNo autopsy within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🗌 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🔀 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) Vo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janet Lu 3901 The Alameda Baltimore Md 21218

Registrar

State

31. Date filed (Month, Day, Year)

2 2 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 1 | 9897 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			Cer	rtifica	ite of L	Death				Reg. No	o.			
Physicia	ın/	Decedent's Name (First, Mid	dle,Last)							2	Date of De			. 1	3. Time of Death	_
Medical Exami	ner	Jimmie	Lee	Hunt	ter Jr						May 27,	2011	1 941		2000 hrs	
		4a. Facility Name (if not institut Prince George's Hos	. •		nber)			City, Town, or Cheverly	Location	of Death	-		lc. County o Prince G		's	
Funeral		5. Social Security Number	6. Sex	7	7. Age (In yrs. la	ast birth	iday)	If Under 1 Year	If Unde	er 24Hrs.	8. Date of E	irth (MN	//DD/YYYY	9. Birt	nplace (State or	
Director		578-06-0069	1X M	X M 2 F 34 Y			Yrs.	Months Days	Hours	Min.	April	12	,1977	Foreigi Cou	Washingto ^{Intry)} DC	'n,
	Ì	Usual Residence of Decedent					'									
v any		10a. State 10b. County	•		10c. City,	Town	or Location	1							10d. Inside City Lin	
and show	5	DC			W	ash:	ingto	n, DC							1 X Yes 2	No
Mary 28a-	5	10e. Street and Number						10f. Zip Code				10g. Ci	itizen of Wha	at Coun	try?	
ith the Maryland 23a or 28a-f she notified at once	₫	822 46th Stree	t, N.E					20	019				USA	A		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1.36 P Year JUNE M 2011 Physician/ GNES Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Baltimore Augsburg Lutheran Home 9. Birthplace (State or Foreign 8. Date of Birth (Month, Pay, Y If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) **Funeral** Hours 1 ☐ M 2 🔀 F 1911 MD June_ 100 214-50-9240 **Director** Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10a. State by Funeral Director Baltimore 1 Yes 2 TNo MD 10g. Citizen of What Country? 10f. Zip Code 21244 10e. Street and Number 3820 Victoria Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Baltimore, Maryland 21215-0036 black If Yes, Give Year or Dates 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) domestic Elementary/Seconday (0-12) homemaker 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Josephine Prettyman ည Caleb Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3820 Victoria Ave., Baltimore, MD 21244 Josephine Dotson (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place)
Bushy Park Cemetery Cooksville, MD 1 X Burial 2 Cremation 3 Removal from State 6-21-11 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licensee P.O. Box 195 Sykesville, MD 21784 Pargesparght Herbert 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EREBRAC Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examine the burial-transit The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23d Date of delivery ed by the attendin detached for use 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year Month Day 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 10 tne runeral Uirector: After this certificate has been signed completed filled in by the funeral director, page 2 should be det þ ZHEIMERS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed 26. Place of Death (Check only one) Hospital or Attending Physician: 1 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical To Be examiner? Other: Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 28b. Time of 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending Natural Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier (Check only or 29d. Date signed (Month, Day, Year) 29b. Signatyre and title of certifie 6 12 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 SMITH IASNEEM 31. Date filed (Month, Day, Year) 62. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 P.O. Records, Division of Vital

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er than "natural", or items 23a of the Medical Examiner must be Completed and Mental Hygiene. is marked other than Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) ည Alskor Hedgespeth 19a. Informant's Name/Relationship (Type, Print) Stephane Lucille Hedgespeth-Department of Health a Important: If item 27 is any injury or other trae 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or peart failure. List only one cause on each line. Immediate Cause (Fnal disease or condition resulting in death) Physician/ Medical **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician a for use as the bunal-Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No signed by the a 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed has page 2 25. Was case referred to medical certificate funeral director, Be examiner? 1 Yes မ 27. Manner of Death Certificate: Natural 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within ¿ Fertifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number D71040 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUMAR 6701 NCHARLES SUTTE 4105 BAITIMORE 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1 7^{Day} Steven Hullett Jume 20 9 1 1 5:30 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Ctr. Bel Air Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Pay, 5. Social Security Number **Funeral** 6. Sex 1**X** M 2 □ F Age (In yrs. last birthday) 9. Birthplace (State or Foreign 58 1 2 / 6 / 1 9 5 2 219-60-8650 Director Japan Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Director MD Harford Havre de Grace 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 118 Remington Circle 21078 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2X Married 1 Yes If Yes, Give Specify:White 1 ☐ Yes 2 X No Specify: 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Medical 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Darrell Hullett Akiko Yuki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Donna Hullett / Wife 118 Remington Circle, Havre de Grace, 21078 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State West Chester, cemetery, crematory or other place)
R.A. Ferris & Co. 1 Durial 2 XCremation 3 Removal from State 6/24/2011 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 21. Signatur Ineral Service Licers Tarring-Cargo Funeral Home, P.A. 1333 S. Parke St, Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Houte lives failure disease or condition Medical resulting in death) Examiner Adenocarcinovna Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence oi) Examin Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Day 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hepatitis C Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Únknown Acute Kidney failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☑ No Division of Vital | Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continuing Number Practice and Discount of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number D 6342D June 18, 2011 (le) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper Chesapeake Dr Bel this MD 21014 Sid. 2. Kharal, NO , 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Physician Medical Examiner

Physician/

Medical

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Baltimore, Maryland 21215-0036

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ed cause of death (Item 23a) (Type, Print)

(Type, Print) 800 WALTHER BIVD, Corkulle MD 2/234

State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene ! For State Registrar Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death 91 Ridg Kesvi 8. Date of Birth (Month, Day, March_5 Social Security Number **Funeral** Age (In yrs. last birthday, 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 X M 2 🗆 F Hours 228-30-3589 83 Country) โว๊28 Director VΑ Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f s Examiner must be notified MD Howard West Friendship 1 - Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3148 River Valley Chase 21794 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces' Black, White, etc. þ 1 Never Married 2 X Married ^{2 □ No} Korea 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Completed 3 ☐ Widowed 4 ☐ Divorced Specify: white Year or Dates if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) sales salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Marion Johnson Effie St. Clair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Richard Johnson (son) 20541 Warburton Bay Square, Sterling, VA 20165 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 6-20-11 Ellicott City, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel ▶ Baig Jought Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conseque ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Year Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Sursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signaty 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 710 Obrech+Road filed (Month, Day, Year) Registrar's Sign Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

OCME

OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Wena Medical tu 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Jan 21 9. Birthplace (State or Foreign Country) DA 1 🗆 M 2 🗔 Months Hours Min Director 077-14-5139 Jan 89 1922 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State Director 10c. City, Town or Location 10d. Inside City Limits MD 1 Y Yes 2 ☐ No Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7426 Village Road Apt. 314 21784 USA 72 hours after death Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces à 1 Never Married 2 Married Yes 2 X No Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 Divorced If Yes, Give Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 I and Mental Hygiene.
7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Senate <u>Administrative Liason</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Meni Important; If item 27 is marke any injury or other traumatic. Rollin Eugene Howe Cristine Hollis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Steven T. Keefe (Son) 2195 Peggy Drive Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Arlington Natl Cem. 18/4/2011 Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA M00769 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner in chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician I be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 JE FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autonsy 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral director. 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes Accident Suicide Investigation 2 🗆 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State Hospital Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Memorial Cham MD 21157 31. Date filed (Month, Day, Year) State 32. Registrar's Sig 22 Registrar

Phy Medical Ex

Baltimore, MD 21215-0036

Physici /Medi Examir Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Villiam Ko	ource	9	State of Maryland	/ Departm	ent of	Health a	nd Mental	Hygiene	_	2011	19905
		1- For State Registrar		Certific	ate of	Death		R	eg. No.	L U 1 1	10000
Physici	an/		e (First, Middle,Last)					2. Date of Dea	th		3. Time of Death
al Exam	ner	John W	illiam Kource					June 18, 2	Day 2 011	Year	2251 hrs
			if not institution, give street and number)	4		or Location of De	eath		County of Death	1
		7024 Eden	Brook Drive			Columbia			H	oward	
Funeral		5. Social Security N		e (In yrs. last bir	thday)	If Under 1 Y				Foreig	thplace (State or
Director		372-42-3	717 1XM 2_F	67	Yrs.		ays Hours I	March	13,	1944 co	untry) Michigan
, A		Usual Residence of									
W any			10b. County	10c. City, Town							10d. Inside City Limits
Maryland 28a-f show d at once.	ō	MD	Howard	Co	lumb						1 Yes 2 No
Mary 28a- d at	MD Howard Columbia 10e. Street and Number 7024 Eden Brook Drive 21046 USA										
3a or		7024 Ede	A.								
death with or items 2	Funeral	11. Marital Status	ed 2 Married Armed Forces				Hispanic Origin? oan, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	- 1	4. Race - Ameri White, etc.	ican Indian, Black,
or it	Ē		1 Yes 2	No	1				- 1.	Wh:	ite
s afte	Ą	3 Widowed	4 Divorced If Yes, Give Year or Dates: ducation (Specify only highest grade cor	anisted) 16a			No specify: pation (Give kind	of words along		specity:	
"nate Exar	ted	Elementary/Seco					ife. DO NOT use		I OD. KII	nd of Business/I	industry
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other tranmatic event, the Medical Examiner must be notified at once	Completed	Elementary/Seco	2		ief V	Warrant	Officer	r	U.S	. Gover	nment
Hygie other	S	17. Father's Name	(First, Middle, Last)				18. Mother's Na	ame (First, Middle, M	vaiden S	Gurname)	
be fil ntal I rked	Be	Raymon	d William Kource				Rita H	Pearl Den	ault		
ould Me is ma	ဥ	19a. Informant's Na	ame/Relationship (Type, Print)	19	b. Mailing	Address (Str	eet and Number	or Rural Route Num	iber, City	y or Town, State	, Zip Code)
d 2 sh lth an n 27			L. Kource Wife					ve; Colum			
f Hea		20a. Method of Disp	position Cremation 3 Removal from St		of Disposi ory or oth	tion (Name of o er place)	emetery,	Date	20c. Lo	ocation - City or	Town, State
Page nent o		-	Other Specify:	Crown	svil:	le VA C	emetery	6/24/11	Cro	wnsvill	e, MD
mit. partn port		21. Signature of Fu		401050	22. N	ame and Addre	ss of Facility S1	terling A Catonsvil	shto	n Schwa	b Witzke
E.E.G.E		41121	C Hadman	0.010 -	163	30 Edmo	ndson Av	venue; Ca	tons	ville,	MD 21228
hysician			ne disease, or complications that caused ly one cause on each line.	the death. Do no	ot enter th	e mode of dyin	g, such as cardia	ac or respiratory arre	est, shock	k, or heart	Approximate Interval Between Onset and
Medical xaminer		Immediate Cause (A4b	Cardiovascu	lar Dise	ease					Death
Adminion		or condition resulting	ng in death) Due to (or es a cons	equence of):							
	ايا	Sequentially list con									
	를	if any, leading to im cause Enter Unde	rlying Gauss	equence or):							
	Examine	(Disease or injury the events resulting in a	nat kilitated	equence of):							1
cuted			d								
te be executed ysician and burial - transit	edical	UNPENDED	AMENDED								
cate b physi he bu	\$	IF FEMALE:	23c. If yes, outcome	ne of pregnancy			_		23d.	Date of delivery	,
ding e as	ल्हा	23b. Was decedent past 12 months	?	time of death		al death 3	Ectopic pre	gnancy	Į M	Month E	Day Year
FEMALE: 23c. If yes, outcome of pregnancy 1											
t the de by the ached f		Part II. Other signif	ficant conditions contributing to deat	h but not resulting	g in the ur	nderlying cause	given in Part I.	23e. Did to	bacco us	se contribute to	the cause of death?
w requires that as been signed b should be detact	Ş	Chronic Alc	cohol Use					1 🗸 Yes	2 🔲	No 3 Prob	eably 4 Unknown
equir een s) je							24a. Was a	an		topsy findings available
law r has b	힐							autop		prior to c death?	ompletion of cause of
The law ificate has l r, page 2 sh	Completed							1 ✓ Yes		1 ▼ Ye	s 2 No
94	- 1	OF 144	. 14			00 =:	(0 11 (0)				

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760,

funeral director, page 2 s

Be

Medical Certification: To

30, Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD 2 2011 State Registra

Assistant Medical Examiner 2. Registrar's Signature

28a. Date of Injury (Month, Day, Year)

and manner stated

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

900 W. Baltimore Street, Baltimore, MD 21223

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Other Nursing Home 5 Residence 6 Other: Scene

or Town, State)

28d. Describe how injury occurred

26.Place of Death (Check only one)

28c. Injury at Work?

29c. License numbe O.C.M.E.

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City

June 19, 2011

29d. Date signed (Month, Day, Year)

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

25. Was case referred to medical

Pending

title of certifie

Investigation

Could not be

determined

DOME

1 Yes

1 🗹 Natural

29a. Certifier 1 (Check only one) 2

2

3

27. Manner of Death

Accident

Suicide

Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	For State	State of Mar		artment of		nd Mental Hy			199	906
			Registrar 1. Decedent's Name (First, Middle, La.	st)	2. Date of De	Reg. No.		3. Time o	f Dooth			
	Physicia						Month	Day 19	2011			
- St.	Medic Examir		Phyllis Madeline 4a. Facility Name (if not institution, give			4b. City, Town,	or Location of D	06		nty of Death	8:30	AM
1			Brightview - Avo	ondell		Bel A				rford		
	Funeral		Social Security Number 6. S		n yrs. last birthday)	If Under 1 Year Months Days	r If Under 24		th	g. Birthp	lace (State o	or Foreign
	Director		011-24-7112	L M 2 LAF	82 Yrs.	Worters Days	nours r	12/18/	1928	Mass	chuse	tts
	how at	=	Usual Residence of Decedent 10a. State 10b. County	11	Oc. City. Town or Lo	cation				1	0d. Inside C	ity Limits
	arylaı a-f s fied	ect	MD Harfor							- [2 X No
	or 28	ä	10e. Street and Number	.u	Bel Air	10f. Zip Code		1	10a Citizen	of What Coun		
	with 1 23a ust b	eral	128 West Ring E	Factory Road	1	2101	4		U.S.		,	
	tems er mi	Funeral Director	11. Marital Status	12. Was Decedent Ever	r in U.S. 13. 1	Was Decedent of	Hispanic Origin:	? (Specify Yes or No-		Race - Americ	an Indian,	
98	fter d , or i amin	ģ	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give		if Yes, specify Cub 1 ☐ Yes 2 🛣N		uerto Hican, etc.)		Black, White, e		
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by	3 Widowed 4 Divorced	Year or Dates.					Spec	ify: Whit	te ———	
7	72 hc n "na ledic	를	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occu kind of work done	during most of	working	1	f Business Ind rd Cou		ablia.
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b	iled I Hy oth vent	Be	17. Father's Name (First, Middle, Last)			ACTICE	18. Mother's	Name (First, Middle,		l Syst	еш	
<u>lar</u>	ould be f d Menta marked matic ev	ပ	Thomas Bird				Made:	line Henry	7	·		
Maryland	should and Me ris mar		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailii	ng Address (Stree	t and Number o	r Rural Route Numbe	r, City or Towr	n, State, Zip C	ode)	
	and 2 s Health tem 27		John Kilroy	(son)	101 I	delity	Road -	Fallston,	Maryl	and 2	1047	
Baltimore,	0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		20b. Place of Dispo cemetery, crer	sition (Name of natory or other pla	ace)	Date	20c. Locatio	on - City or To	wn, State	
Ë	Page ment o tant: If jury or		4 ☐ Donation 5 💢 Other (Special		Druid Ric	dge Ceme	tery 06	/24/2011	Baltin	ore,Ma	rylan	db
3ali	permit. Departr Importa any inju		21. Signature of Funeral Service Licens	see				E. F. Lass			•	
_	TD = 8 0		C. J. Va	ssaln				d - Kingsv		Maryla	nd 2'	1087
			23a. Part 1. Enter the disease, or comshock, or heart failure. List only of	ne cause on each line.				27	rest,		Approximat Interval Bet	ween
	hysician/ Medical	î î	Immediate Cause (Final disease or condition resulting in death)	a. Eusl	onsequenc f):	Curla	munt	26			Onset and I	Death
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		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	onsequence of):					-		
	uted ansit	ami	cause, Enter Underlying Cause (Disease or iinjury							1		
	execu an an	EX	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):							
09	icate be executed g physician and is the burial-transit	dical Examine	•	d								
87	tifical ng ph		IF FEMALE:									
Box 687	eath certifica attending p	jan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3		псу			Date of delive		
B	the at	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at tin 9 ☐ Unknown	ne of death 5 L	Other (specify)				Month	Day `	rear .
P.O.	at the		Part II. Other significant conditions of	ontributing to death but r	not resulting in the u	nderlying cause g	iven in Part I.	23e Did to	bacco use co	entribute to the	e cause of d	eath?
S,	res the signer of the contract	d b	congestive L	1					Yes 2 □ No			
Ď	requi	ete	7	V				24a. Was		o. Were autop		
Division of Vital Records,	e law e has ge 2 :	Completed by						— autor		prior to cor death?	npletion of c	
<u> </u>	n: Th fficate or, pa		25. Was case referred to medical			26. 5	Diago of Dooth //	1 🗆 Yes	2∪ No	1 🗆 Yes	2 🗀 No	
/ita	Physician: T r this certifica ral director, p	To Be	eyaminer?	Hospital:	2 ER/Outpatier	LOH	Place of Death (C		· 200		Assis	sted
of	g Phy er this neral o		27. Manner of Death	28a. Date of injury	28b. Time of	28c. Inju	ry at	g Home 5 Resid			Livir	
o	andin ath. rr: Aft	ical	1 Natural 5 Pending 2 Accident Investigation		ear) injury	M 1 🗆	·k?]Yes 2 ☐ No					
/ISI	r Atte ter de recto	Certificate:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre	et, factory, office		28f. Location (S City or Tow		ber or Rural	Route Numb	er,
	ital ours af	a										
:	Hosp 24 ho Fune sted fi	edical	(Check 2 Medical Exami	sician: To the best of my ner: On the basis of exam	ination and/or invest	igation, in my opin	ion, death occur	red at the time, date a	nd place, and	due to the cau	se(s) and ma	nner stated.
,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. The Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Σ∣	only one) 3 L Certifying Nurs 29b. Signature and title of certifier	se Practioner: To the bes	t of my knowledge, c	leath occurred at the 29c. Licens	he time, date and	place, and due to the	e cause(s) and	manner as sta	ted.	
	F > F 0	290. Signature and title of certifier 29d. Date signed (Month, Day, Month) Day, Month, Da										
			30. Name and address of person who o	completed cause of death	(Item 23a) (Type P		221)		1000		-0)	
			DOV D 5 1	,	, , , , ,	,	ad Rel	Air, MD	21014			
	Stat	~	31. Date filed (Month, Day, Year)	32. Registra/s	Signature						· -	
	Registra	r	IIINI 2 2 2011	MARINE 1.	1							

DHMH 17 Rev 7/2009

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DHMH 17 Rev 1/2001 OCME 2006

State Registrar

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD

Assistant Medical Examiner

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

June 20, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Jane Ann Clapper Lewis 6:07 AM 2011 Tillne /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore St Agnes Hospital 8. Date of Birth (Month, Day, Year) Aug. 29, 1944 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F 219-44-9741 66 Maryland Director Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Director MD Dickeyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2302 Tucker Lane Funeral 21207 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐Yes 2 ☒No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or iter 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 1 No Specify þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Desktop Publishing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Price Clapper Erma Mae Perry ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 2302 Tucker Lane; Dickeyville, MD 21207 Donald Lewis Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Balt, Wash. Crematory 6-19-2011 Laurel, Maryland 4 ☐ Donation _ 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signa of Funeral Service Licensee Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARDIOGENIC Physician SHOCK HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Months ANCREATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) been signed by the should be detached 1 □Yes 2 1No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 2□10 1 ☐Yes 2 ØNo 1 ☐ Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes & No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: At completely filled in here. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Madrata P25924 June, 15, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S CATON AVENUE, BALTZMORE, MD 21229 PATEL 900 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ GLADYS LACOVARA JUNE 2011 2:30A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Roland Park Place Baltimore Baltimore City Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) (Month Day Year) av 7.1918 1 □ M XX F Days Hours Min 93 **Director** 557~36~4067 May Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Ħ Director Examiner must be notified or 28a-f XX Yes 2 No Maryland Baltimore City Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 830 W. 40th St. Apt. 362 21211 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. ò ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify Completed XX Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important; If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Anesthetist Flushing Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Camerer Ida Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4204 Somerset Place Baltimore, Md. 21210 Janis A. Pinto (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Flushing Cemetery 20c, Location - City or Town, State X1X Burial 2 Cremation 3 Removal from State 6-23-2011 |Flushing, New York 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ASPLVATION pheumonia Physician/ Medical resulting in death) Due to (or as a onsequence of) Examiner Sequentially list conditions, Examin cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 2. No 1 ☐ Yes ∠ J 9 ☐ Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by dimentia 1 Yes 2 No 3 Probably 4 Unknown Briast CAYCLINOMA Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes 2L Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one)

State Registrar

NHMH 17 Rev 7/2009

29b. Signature and title of certific

HILLANY

n MC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DON.

m - D -

32. Registrar's Signature

29c. License number

5901 North CHAVLES Street

035102

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month Jerome Levin : 55 A M 7011 JUANE Medical Examiner 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 TTY 8 Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 XM 2 □ F Months Days 07/04/1921 Director Yrs 071-12-3558 89 NY Usual Residence of Decedent 28a-f show 10b. County 10a. State 10d. Inside City Limits iral", or items 23a or 28a-f shor Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No MD BALTIMORE BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 126 SHERWOOD AVENUE 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 IAYes 2 □ No If Yes, Give Year or Dates. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 X Married "natural", or 1 Yes 2 X No Specify Completed 3 Widowed 4 Divorced Specify: WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ **PSYCHOLOGIST PSYCHOLOGY** other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental H ഉ HENRY **STEUER** - STOYER LEVIN MINNIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other traus PATRICIA LEVIN/WIFE 126 SHERWOOD AVENUE, BALTIMORE, MD 21208 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 06/21/2011 OWINGS MILLS, MD 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ End. Stage (ardiomyopath disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Pregnant at time of death 2 No ed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital 4 Nursing Home 5 Residence 6 Other Specify ent hospice Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) the Hospital or Attending 1 Natural injury work?
1 Yes 2 No 5 Pending 2 Accident Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number upleted filled in by 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier MSRM W WM . O. 29d. Date signed (Month, Day, Year) 29c. License number 00057465 6/19/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-703 Baltimore MD 21209. N. S. Rajapakse, M.D. 2835 SMITH 31. Date filed (Month, Day, Year) . Registrar's Signa State JUN 2 2 2011 Registrar

Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10c per fh 2916 6-22-11 vt State of Maryland / Department of Health and Mental Hygiene | for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JUNE Day 20 Physician/ SHIRLEY SANDLER LIPSITZ 2011 3:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE ENVOY OF PIKESVILLE PIKESVILLE Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9, Birthplace (State or Foreign **Funeral** 90 Days Hours Min 07/03/1920 218-36-5647 Months MD **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director BALTIMORE MD BALTIMORE 28a-f 1 Yes 2X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Hygiene. other than "natural", or items 23a or rent, the Medical Examiner must be r Funeral 6634 SANZO ROAD APT. E 21209 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME and Mental Hygie is marked other Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is mark--any injury or ---NATHAN HERR SOPHIE RIFKIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES SANDLER/SON 3746 ASHLEY WAY, OWINGS MILLS, MD 21117 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State SHAAREI ZION CONG. 06/21/2011 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of Examir burial-transit and Due to (or as a consequence of) nding physician use as the burial Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atter in the past 12 months?

1 Yes 2 No o Day Year Month Pregnant at time of death signed by the a Unknown P.O. Part II. **Other significant conditions** contributi*n*g to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, 1 Yes Completed should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 has autopsy certificate 1 Yes 2 No Yes the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certific Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one. Be examiner? Other 1 Tyes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann f Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a, Certifie certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 000 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 10e per fh e916 6-28-11 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 20:09 M TUNE Medical 4a. Facility Name (is not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Months Hours Min Country) 570-44-9810 Iowa Director Usual Residence of Decedent show 10a, State 10c. City, Town or Location within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director MD Howard Ellicott City 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10054 11054 Green Clover Drive 21042 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates SpecifyWhite 1 Yes 2X No Specify. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home traumatic event, Be 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Donald Black Margee D. Rehm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10054 Green Clover Dr., Ellicott City, 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shr Department of Health an Important: If item 27 is any injury or other traus Robert F. Margotta/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Final journey Crem. 06/24/2011 Woodbine, MD 4 Donation 5 Other (Specify) re of Funeral Service Licensed Dorota Marshall 22. Narmand Address of Briller remation Services PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) -ev neun Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 1 ☐ Yes ≥ □ 9 ☐ Unknown g 🗌 Unknown signed by the second Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s performed this certificate 2 🗌 No Yes 2X No 1 Tes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospita 1 Tyes 2 XNo မ 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examines On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examine: On the basis of examination array of investigation, it my opinion, south a state and place, and due to the cause(s) and manner as stated Certifying Number Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) June 19, 2011 6487 address of person who completed cause of death (Item 23a) (Type, Print) 5755 Codar Long Colubia, MD 21044 81 Bavani 2 31. Date filed (Month, Day, Y 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ Day 2011 Year JUNE 20 ernice 8:04p M usgrove Medical 4a. Facility Name (if not institution, give street and Momber)

GREATER BALTIMORE MEDICAL CENTER TOWSON **Examiner** 4c. County of Death BALTIMORE Social Security Number Age (In yrs. last birthday)
78
Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 V Thonth Day, 212-28-2814 MD**Director** Usual Residence of Decedent 28a-f shov 10b. Count 10a, State 10d. Inside City Limits filed within 72 hours after death with the Maryland Funeral Director Examiner must be notified more 1 Yes 2 No ò 10e. Street and Number 10g. Citizen of What Country? 23a MUS GROVE, VERVICE USA "natural", or items Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 MNo
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify 3 Widowed 4 ☐ Divorced slae Year or Dates 27 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
ke. DD NOT use retires) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Edllege (1-4 or 5+) Elementary/Seconday (0-12) lears Be 17. Father's Name (First, Middle, Jast) t. Page 1 and 2 should be file tment of Health and Mental rtant; If item 27 is marked o 2 ornis vangeline vans own, State, Zip Code) 21133 19b. Mailing Addr permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 20a. Method of Disposition Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Si x a re of Funeral Service Licer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Hodgekin Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence or). attending physician and for use as the burial-transit Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Second at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: မှ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. Investigation M Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) D0060248 Unawar and address of person who completed cause of death (Item 23a) (Type, Print) North Charles Street Greenanatt. MD 6701 State Registrar DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month Major D aphne 6:26 AM Trine Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3306 Greenmead Road Windsor Mill Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, You 3-8-1920) 1 □ M 2 🕅 F Months Hours Min. Year) **Director** 2**11-12-137**9 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 XNo MD Baltimore Windsor Mill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be r Funeral 3306 Greenmead Road with 21244 USA items ? Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iten edical Examiner r Armed Forces? 1 \(\text{Yes} \quad 2 \) \(\text{X} \) No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🎇 No Specify. Specify: African-American Completed 3 X Widowed 4 □ Divorced er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygiene. Item 27 is marked other that other traumatic event, the A 12th Manager Cleaners Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Lee Schutchings Bea Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel E. Dorsey Jr./Son 3306 Greenmead Road, Windsor Mill, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o once, 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) GreenAcres Memorial Park 6-23-2011 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service Lice et 9200 Liberty Road, Randallstown, MD 21133 23a. Part . Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an cate has page 2 s autopsy performed 24 hours after death.

Funeral Director: After this certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 🗹 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MSRAJApaneM.O D0057 6/18/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N . 5 Rajapa VSL 1 M.D 2835 Smith Av Baltimor MD 21209. N. 5 Kajaparse, M.D -203 31. Date filed (Month, Day, 32. Registrar's Signature JUN 2 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** AM M 2:17 June 10, 2011 Bernard M. Melsage /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Boonsboro Washington 6104 Vantage Court Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 ☑ M 2 ☐ F 219-32-8971 77 Feb 14, 1934 Colorado Director Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ortant; if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Everying to other traumatic event even 1 ☐ Yes 2 ☐ No Director MD Washington Boonsboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6104 Vantage Court 21713 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 156-5 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: white þ 3 X Widowed 4 ☐ Divorced 156-58 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygien important: if item 27 is marked other than "any injury or other traumatic most." Elementary/Secondary (0-12) College (1-4or 5+) state highway adm surveyor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Parker Bernard Martin Melsage 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6104 Vantage Court Boonsboro, MD Renee Williar/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) 21. Signature of Edneral Service Licensee Daniel A. Naylor ^{22.} Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final months Carcinoma Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical signed by the attending IF FEMALE: 23d. Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Ve ar 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 □ No 2 **N**o 1 Yes 1 ☐ Yes Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? 5 Residence 6 ☐ Other (Specify) Other: 4 🖺 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide the Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ٥ - Sands, mo June 13, 2011 Kuther D4745 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washing for Eynthia Kuther-Sands, no Hospice of Hospice County, 747 Northern Avenue Maryland 21742 32. Registrar's Signature 31. Date filed (Month, Day, Year) State park Registrar Deneva B

DHMH 17 Rev 1/2001

Ry Rolanduf Murray Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Roy Rolandus Murray Jr. Physician/ Month Day June 12, 2011 0543 hrs Medical Examiner Roy Murray Jr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 2600 Park Heights Terrace If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Director 10 Country) MD 02 219-98-7946 1 XM 2 F 29 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 No Show Baltimore Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygone.

aut. If Item 27 a marked other than "natural", or items 23a or 28a-f aho or other tramanic event; the Medical Examiner must be notified at ouce. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number U.S.A. 21217 1300 Pennsylvania Ave Apt Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 1 Yes 2 X No Specify: Black 1 Yes 2 X No specify: If Yes, Give Year 3 Widowed 4 Divorced \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed timore, MD 21215-0036 Unemployed na llth grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bridgett Hopkins Paul Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2 4615 Wallington Ave, Baltimore, Md 21215 Sherry Blackwell-Sister 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Important: I injury or other Baltimore, Md 6/25/2011 Zion Mt. Donation 5 Other Specify. nature of Funeral Service Licens 22. Name and Address of Facility March F/H West 21215 Baltimore, 4300 Wabash Ave. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and Inlure. List only one cause on each line /Medical Death a. Multiple Gunshot Wounds immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - trans Physician/Medical X AMENDED 1 per me g916 6-24-11 vt UNPENDED Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown for 9 Unknown signed by the the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Š 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available certificate has been rector, page 2 should 24a Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical Division of Vital Other Nursing Home 5 Residence 6 🗸 Other: Scene examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injury 27. Manner of Death Subject shot Jun 12, 2011 0520 hrs Natural 1 Yes 2 ✔ No 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 __ Could not be or Town, State) 2600 Park Heights Terrace, Park Heights, MD determined (Specify) Alley 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the asis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. June 12, 2011 30. Name and address or person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Deputy Chief Medical Examiner **OCME** Mary G. Ripple MD. 32. Registrar's signature JUN 2 2 20 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1456 Physician/ 2011 Moore Lensy 56 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Union Memorial Hospital If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Months Days Hours Min. Country) 1 X M 2 🗆 82 Director 218-22-3516 NC 0528a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ Director 1 Xyes 2 □ No Examiner must be notified Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 items 23a Funeral U.S.A. 21215 3400 Cotwood Place 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. P. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City <u>Truck Driver</u> 10th grade na other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emma Pettiford Rufus Moore 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3400 Cotwood Place, Baltimore, Md 21215 William Moore-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State any injury or King Memorial Park 6/23/2011 Woodlawn, 4 Donation 5 Other (Specify) rignature of Foneral Service Licenses 21. 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Cardiac disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Cardiogenic Shock Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine and ischmic Cardiomycopath Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Metastate Prostate Cancer Physician/Medical P.O. Box 68760 attending as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death Jse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ō Month Day Year Pregnant at time of death yes 2 □ No g Unknown been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 : autopsy performed? Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ပ္ 1 🗌 Yes 1 XInpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 5 Pending injury 1 🔲 Yes 2 🗌 No death. within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brandon Lebrur, MD union Warnivial Hospital Department of Medicine 2018 University Perkuray Bellinia and 21218 31. Date filed (Month, Day, Year) 32. Registrar's Signature State varke

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Registrar

Please Type or Print in Black Indelible Ink English Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Brenda Yvonne Parks 6/4/201 Medical 1:01 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A 2025 N. Fulton Ave. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. (Month, Day, Year) Country) Director 26-44-0965 /20/1954 NV Usual Residence of Decedent permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 28a-f show 10a. State 10b. County 10d. Inside City Limits Director 10c. City, Town or Location 1 X Yes 2 No DC N/A Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20011 1205 Farragut USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1X Never Married 2 ☐ Married Completed by Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Specialist Federal Gov. yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Robert Parks Louise Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adrienne Parks-Sister 2025 N. Fulton Ave. Baltimore, MD 21217 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Mem. Cemt 6/13/2011 Suitland, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility March F/H 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Entra in disease, or complications that caused shock, an eart failure. List only one cause on each line. Immediate Cause (Final or complications that caused the death. Do not enter the mode pf dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ D)(disease or condition resulting in death) en (a Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant a 5 Other (specify) Month Day Year Pregnant at time of death Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) sisiter's 2 No Hospital ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 \quad Yes 28d. Describe how injury occurred Natural injury 5 Pending Investigation 2 No Accident in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aff

To the Funeral Di

completed filled in Medical 1 💬 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 30. Name and add who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

			Please Type or Print in Black								
		_	1 - State Registrar C	partment of Health and ertificate of Death	F	Reg. No.					
	Physicia Medic	al	1. Decedent's Name (First, Middle, Last) Robert M Parker 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deatl	2. Date of Dea Month	Day Year S:15 A M					
	Examin	er	Anne Arundel Medical Center	Annapolis	n	Ac. County of Death Anne Arundel					
	Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>în yrs. last birthda</i> 579−54−0139 7. Age (<i>în yrs. last birthda</i> 7. Age (<i>in yr</i>	Months Days Hours Min.							
	and show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits					
	Maryl 28a-f notifie	Director	MD Prince George's Fort Was			13€ Yes 2 □ No					
	vith the 23a on st be		10e. Street and Number	10f. Zip Code		10g. Citizen of What Country? USA					
	death items	Funeral	1800 Palmer Road apt # 204 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian, Black, White, etc.					
9000	urs after (tural", or al Examir	ted by	1 ☐ Never Married 2 ♣ Married 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates.	1 ☐ Yes 2 X No Specify:		Specify: Black					
215-	72 ho an "nat Medica	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of woi . DO NOT use retired)		16b. Kind of Business Industry					
212	ygiene ygiene her th: nt, the	ادہ ا	12th Dire			Private					
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, Last) Isacc Parker	Bertha	me (First, Middle, i McGriff						
Mar	2 shou Ith and 27 is m traum			ailing Address (Street and Number or Ru O Palmer Road apt.		; City or Town, State, Zip Code) Washington, MD 20744					
ore,	ge 1 and nt of Hea : If item		Dialon italy	sposition (Name of	Date	20c. Location - City or Town, State					
Baltimore,	t. Pa tmel tani	- 3	4 Donation 5 Other (Specify) Metropol	itan Crematory 06/2		Alexandria, VA					
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee	4308 Suitland Road		March Funeral Home					
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.								
	Pnysician/ Medical	i	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	les (ANCEY		WAY.					
	Examiner	_	Sequentially list conditions, b.								
	ed sit	Examine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury)								
	executed an and rial-transi	al Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):								
09/	ate be physici the bu	edica	d								
Box 68760	certific ending use as	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death	3 Fetopic pregnancy		23d. Date of delivery					
. Bo	ne death y the atte ched for	Physician/Medic		5 Other (specify)		Month Day Year					
s, P.O.	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	d by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		obacco use contribute to the cause of death? Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown					
ord	w requi	Completed by			24a. Was autop						
Rec	The la				perfo 1 🗆 Yes	rmed? death?					
/ital	sician certifi	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpa	26. Place of Death (Che		dence 6 Other (Specify)					
n of \	ding Phy th. After this funeral o		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) injure injure.	e of 28c. Injury at	_	ow injury occurred					
Division of Vital Records,	I or Atter after dea Director: I in by the	Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (S City or Tow	Street and Number or Rural Route Number, n, State)					
	To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: The this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the temperature.	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or in only one) 3 Certifying Nurse Practioner: To the best of my knowledge, dea	vestigation, in my opinion, death occurred	at the time, date a	nd place, and due to the cause(s) and manner stated.					
	To the within To the comple	2	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)					
	3		DO NOT THE REAL PROPERTY OF THE PARTY OF THE	D64089		6/17/2011					
	J &		30. Name and address of person who completed cause of death (Item 23a) (Type MWK Sqnthtz MD 2001 Me		mapelis	MD 21401					
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 2 2011 Across A. Registrar's Signature	,	, ,						

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

IIIN 2 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16 Month June Physician/ Emma Ruth Russell 2011 8:30A M Medical County of Death
BALTIMORE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** TOWSON GILCHRIST CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye April 21 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Min. Months Days Hours 1 M 2 F Ohio 233-34-2883 86 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director notified 1 Yes 2 X No Baltimore County Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code Ö 10e. Street and Number "natural", or items 23a or Funeral USA 21237 2343 Hamiltowne Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 X Married ģ 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates White Specify: 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 yrs. College (1-4 or 5+) N/A Homemaker Homemaking-Own Home other Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F Paul Hamilton Osie Riley permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Russell (Husband) 2343 Hamiltowne Circle Baltimore, Md. 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XX Burial 2 Cremation 3 Removal from State Dulaney Valley M.G. Baltimore, Md. 4 Donation 5 Other (Specify) 6-22-2011 7401 Belair Rd. 22. Name and Address of Facility nature of Funeral Service Licenses Lassahn Funeral Home Balto., Md. 21236 ithou 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ static cancer 1 cars disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions if any leading to immediate cause. Enter Underlying Due to or as a consquence of: Exami Cause (Disease or linjury that initiated events resulting in death) Last physician and s the burial-transit Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 2 No 3 Probably 4 Unknown Records. 1 Yes perment's Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 2 310 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury 1 Natural 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 701 at 31. Date filed (Month, Day, 32. Registrar's Signature JUN 2 2 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6:46PPhysician/ JUNE 19^{Pay}2011^{ear} Robert P. Robinson Medical 4a. Facility Name (if not institution, give street and number)
ST JOSEPH MEDICAL CENTER Examiner 4b. City, Town, or Location of Death ^{4c}BALTINORE TOWSON Sex 1 XM 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 35110 Days Director MD Usual Residence of Decedent items 23a or 28a-f shov ier must be notified at 10b. County 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Directo Baltimore 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 21215 udaate Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. "natural", or ite Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 ₩idowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Security 4 years Social Claims Representative Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert A. Robinson LICY arter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert R 20a. Method of Disposition 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Jarrison 2011 Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Green & Funeral STVG 23a. Part 1. Enter the di sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ire. List only one cause on each line. shock, or hea Interval Between Onset and Death Immediate Cause PULMONARY EMBOLUS Physician disease or conditio MINUTES Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pi IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Pregnant at time of death Month Year signed by the a Id be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to DEMENTIA death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 autopsy performed?

1 Yes 2 No death? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D62551 6.20.11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIC J. BEAUVOIS, M.D. 7601 OSLER DRIVE TOWSON, MD 21204

DHMH 17 Rev 7/2009

State Registrar

	-	For State Registrar		State of M	Maryland		th g916 artment of h			Re	g. No.		17.	<i>)</i>
Physicia /Medic			er w,	2 iddick S				- Lastina	j	Date of Deatl Month	Day	Year 301	3. Time o	
Examin	er			ive street and numbe			4b. City, Town, o		of Death		4c. Cou	inty of Death		
-		Jonns Hop 5. Social Security		riew Medical	Age (In yrs. la	st birthday)	If Under 1 Year	If Under	24 Hrs. 8.	Date of Birth	Vear	9. Birth Cour	place (State	or Foreig
Funeral Director		223-26-1		1 X M 2 □ F	88	Yrs.	Months Days	Hours	Min.	07-21-	1922	NC.	VA.	
show d et		Usual Residence of 10a. State	10b. County		10c. City,	Town or Lo	cation	** .					10d. Inside (•
fied e	cto	MD	BALTI	MORE		TURNER	STATION	-						s 2 🗆 N
or 28 e noti	Director	10e. Street and N	umber				10f. Zip-Code			11	0g. Citizen	of What Cou	ntry?	
IS 23a Tust b	Funeral	420 CHES	STNUT CT.	12. Was Decede	nt Ever in U.S	13.	Was Decedent of I	1222 Hispanic Or	igin? (Specify	Yes or No-		ISA Race - Ameri	can Indian,	
r Item	F	 Marital Status Never Ma 	med 2X Married	Armed Force	157		f Yes, specify Cub	an, Mexicai	n, Puerto Rica	n, etc.)		Black, White,		
el", o Exam	ğ	3 🗌 Widowed	4 Divorced	If Yes, Give Year or Dates			1 □ Yes 2 No	Specify:				ecify: BLA		
natur dical I	etec	(Sp	15. Decedent's ecify only highest			(Give	dent's Usual Occu kind of work done	during mos	st of working	- 4	16b. Kind	of Business/li	ndustry	
than "	Completed	Elementary/Se	condary (0-12)	College (1-4 o	or 5+)		DO NOT use retire LAYER	iu)			BUILI	TNG		
Hygie ther 1 int, th	ပိ	17. Father's Name	e (First, Middle, La			DKLC	TIMI LIK	18. Moth	er's Name <i>(F</i>	irst, Middle,				
nd Mental Hygiene. marked other than metic event, the Me	P B	LEE RI	IDDICK						SE PA					
if Health and Mental Hygiene. Item 27 Is marked other than "naturel", or Items 23a or 28a-f s other treumetic event, the Medical Examiner must be notified		19a. Informant's I	Name/Relationshi				ng Address (Stree CHESTNUT							
te has been signed by the attending physician and a population of Health are page 2 should be detached for use as the burial-transit a population of the page 2 should be detached for use as the burial-transit a population of the page 2.	by Physician/Medical Examiner	23a. Pahr 1. Enter shock, or he Immediate Cause disease or condit resulting in death Sequentially list of if any, leading to cause. Enter Uncause (Disease of that initiated ever resulting in death IF FEMALE: 23b. Was deceded in the past 1	the disease, or content failure. List or to (Final ition) conditions, immediate derlying or mijury atts and pregnant 12 months? 2 □ No yn	b. Due to (or d. 23c. If yes, outco	as a consequence of pregnation at at time of definition.	ncy death 3 sath 5	2. Name and Addr 1701 LA ter the mode of dy	AURENS Ving, such a	ST.,	S A. N BALTO.	MORTON MD rest,		Approximinterval B Onset an Uniterval B Onset an Uniterval B Onset and Uniterval B Onset	nate Between Id Death Hand
has be	Completed							-		24a. Was a	in .	24b. Were au prior to death?		os avail
		25. Was case ref	erred to medical					26. Plac	ce of Death (C					
s certifica director,	To Be	examiner? 1 ✓ Yes 2	□No	Hospital: 1 🗆 Ing	patient 2	ER/Outpatie	nt 3□DOA O	ther: 4 🗆 N	lursing Home	5 🗆 Resid	lence 6	Other (Spec	cify)	
ding Phys h. After this funeral d	Medical Certification: T	27. Manner of De 1 Matural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	5 ☐ Pending investigation of ☐ Could n	28a. Date of (Month, ation of be 28e. Place of	Injury Day Year)		[W	ork? □ Yes 2 □	No	d. Describe to Location (City or Tow	Street and i	occurred Number or R	ural Route N	vumber,
within 24 hours after deat To the Funeral Director: completely filled in by the	dical (29a. Certifier (check only one)	1 🛭 Certifying 2 🗌 Medical E	Physician: To the be examiner: On the bas and manne	is of examina	wledge, dea tion and/or i	th occurred at the nvestigation, in m	time, date a y opinion, d	and place, an eath occurred	d due to the I at the time,	cause(s) a date and p	nd manner a place, and du	s stated. le to the cau	ıse(s)
within To the comp	Me	29b. Signature a	nd title of certifier	,,,	no		1	nse number	1			igned (Mont		,
		(1)	ddress of person	who completed cause	of death (Iter	n 23a) (Type	e, Print)	4	940 Eas	stern A	/enue,	Baltim	ore, MI), 21:

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State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month novolsa Medical 06 2011 11:00a. 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 5918 Cross Country Blvd Apt Baltimore 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) Months Hours Min (Month, Day, Year) Director 213-52-131 01Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1 Xes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 U.S.A. 5918 Cross Country Blvd Apt C 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify: 3 XWidowed 4 □ Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working South Baltimore life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Supply Technician General Hospital <u>10th grade</u> na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Claude Jones Emma Taylor permit. Page 1 and 2 should bepartment of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208 \$501 Mountainholly Drive, Pikesville, Janice Gordon-Daughter or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury o 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn 6/24/2011 Woodlawn, Md cture Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, any Baltimore, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ease or condition Due to (or as a consequence of) Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) -transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No signed by the at d be detached for the Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown plnods Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Certificate: To 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After t 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Af 1 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 <u>|</u> 3 <u>|</u> Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) H68214 June 20, 2011 p. 0. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Régistrar's Signature State 2 2 2011 Registrar

		- Laure
State of Maryland	/ Department of Health and Menta	l Hygiene

			For State Registrar	Otate of IV	iai yiai iu		tificate of				gierie Reg. No			
ı	Physicia		1. Decedent's Name (First, Middle Kathleen	a, <i>Last)</i> Ann Stottle	mire					Date of Dea Month UNE	ith Day	y 20 ^{Year}	3. Time	of Death
	Medi Examir		4a. Facility Name (if not institution			2	4b. City, Town, c	or Locatio		ONE		County of Dea		101
A	Funeral		5. Social Security Number	6 Say 7 Ac	Say 7 Ago /In use lost highday) If Lindar 1 Year					Date of Birtl	n l	9. B	MOR E	e or Foreign
7	Director		217-88-9842 Usual Residence of Decedent	1 M 2 T	50	Yrs.	Months Days	Hours	Min. A	pr 16	Year C	961 °	ountry) MD	
	yland f show ed at	į	10a. State 10b. County		10c. City,	Town or Loc	ation				_		10d. Inside	
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	h with t ns 23a nust be	neral	5225 High Tim	ber Drive			211	.58			10g. Citizen of What Country? USA			
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 😿 Mar 3 ☐ Widowed 4 ☐ Divorced	ied 12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.			Vas Decedent of H Yes, specify Cub. ☐ Yes 2 ☐ X lo			es or No- n, etc.)		14. Race - American Indian, Black, White, etc. Specify: White		
15-(72 hou in "nate Medica	mplet	(Specify only highe	nt's Education st grade completed)		(Give k	ent's Usual Occup ind of work done ONOT use retired	during mo	ost of working		16b. Ki	nd of Business	Industry	
212	y within ygiene. her tha	ம	Elementary/Seconday (0-12)	College (1-4 or s	5+)		ger of I		Service	s	НС	Public	School	ls
land	l be filed fental H rked ot tic ever	To B	17. Father's Name (First, Middle, L John Leonal	^{ast)} rd Bewley, S	r.				ther's Name <i>(Firs</i> Regina		Maiden S	Surname)		
Baltimore, Maryland 21215-0036	nd 2 shoulc ealth and N m 27 is ma	77)	19a. Informant's Name/Relations Mr. Allen M. S				g Address (Street High Tin							
nore	age 1 and of H of H of H itel		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 Removal from State	cen	netery, crem	sition (Name of atory or other place		Date	011		cation - City o	,	
altir	permit. Pa Departme Importan any injur		21. Signature of Funeral Service L		ATT		Name and Addre					esvill HOME		T DA
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- 1	Ph, sician/ Medical	i 17	Immediate Cause (Final disease or condition resulting in death)	nly one cause on each line BREAS	T CA	NCER,	METAS'	TAT I	C	orratory arre	est,		Approxim Interval B Onset and	etween
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8760	cate be physic s the bu	Medical	<u>ö</u> d											
Box 68	ath certif attending for use a	_	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal d	leath 3 🗌	Ectopic pregnand Other (specify)	су			2	23d. Date of de Month	elivery Day	Year
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	ne Hosk n 24 ho ie Fune oleted fi	Medical	(Crieck Z L Medical E	Physician: To the best of caminer: On the basis of ex Nurse Practioner: To the	kamination ar	na/or investic	ation, in my opinio	on, death (occurred at the fir	me date an	dnlace	and due to the	called(e) and m	nanner stated.
	To the complete of the complet		29b. Signature and title of certifier	1 Leffay	- 0.0		29c. License				9d. Date	signed (Mont	h, Day, Year)	i
	10		30. Name and address of person v	/ho completed cause of de	eath (Item 23 7601	a) (Type, Pr OSL	int) ER DRI\	E T	OWSON,	MD .			,, ===	,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year (BER SMITH THA 20 p.M UNE Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death 4520 Vermeer Court Owings Mills Baltimore . Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 1 □ M 2 X F Months Hours Min 12-18-1932 212-40-5856 Director 78 MD Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Owings Mills 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4520 Vermeer Court. 21117 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Never Married 2 Married 3 Widowed 4 Divorced Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: African-American If Yes Give Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Assistant Church Home Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Travers Cecelia Willis permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Smith Ricks/Dauchter 3816 <u>Yolando Road, Baltimore, MD 21218</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Western Cemetery Baltimore, MD 6-20-2011 4 Donation 5 Other (Specify) Wylie Funeral Home P.A. of Baltimore Co. 21. Signature of Funeral Service Lice 22. Name and Address of Facility 9200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a Part 1. Enter the disease Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CARDIO VASCULAN disease or condition HTHEROSCLEROTIC YEAR Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a non-sequence of: if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed -trans and Due to (or as a consequence of): resulting in death) Last the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year led by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an performed? Yes 2 No death? After this certificate 2 🗍 No within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 192510 asanthalama MD JUNE 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIVASANTHAKUMM ROLLING ROAD # 108 MD 21228 516. N 31. Date filed (Month, Day 32. Registrar's Signature State Registrar

Registrar

BALTIMORE

MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMAL (SAIAH 22 S GREENE ST BALTI

32. Registrar's Signature

31. Date filed (Month, Day, Year)

2 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lottie Smith Year 1:15 P June Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Beason 2 Hospice - N.W. Randlestown 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) Birthpiac Country) **Funeral** Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 1 🗆 M 2 🖵 🗜 Days Hours 081-24-2210 Director 94 3/17/17 Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MD N/A Baltimore 1 Yes 2X No 23a c. 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4800 Yellow wood ave USA 21209 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, ih and Mental Hygiene. 27 is marked other than "natural", or itel traumatic event, the Medical Examiner Armed Forces? Completed by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 AFRICAN 1 ☐ Yes 2 ☑ No Specify: If Yes, Give 3 √Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gaither Heggins Heggins Jeneva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Department of Health Important; If item 27 any injury or other to Mary Harris e derr Drive, Baltimone, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clen Burne MIN Clm 22. Name and Address of Facility
Havi F- Wose Fun
5/26 Beturn Rd, / Signature of Funeral Service Licens Senerce P.A. SIS OM 40 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Annroximate Interval Between Onset and Death Immediate Cause (Final Cardiorascular Atheros Ckrotic Ph. sician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): sician and burial-transit Exami Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical certificate be Box 68760 as the t IE EEMALE nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year signed by the a 1 Yes 2 No g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, the Hospital or Attending Physician: The law requires thin 24 hours after death.

the Funeral Director: After this certificate has been sign 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 - Nursing Home 5 - Residence 6 Tother (Specify) evit huspice 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 1 Tes 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MskajapahuM.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209 N. S. Rajapake, M.D 5-203 2835 Smith 31. Date filed (Month, Day, JUN 2 2 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sune arence simps or 2011 13 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Burnie ANNE ARUNDEL Medical Center Glen If Under 1 Year I If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗶 M 2 🗆 F Days Months February 12, Country) **Director** 376-38-1613 70 Ohio Usual Residence of Decedent show 10a. State 10b County Ħ 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sh notified Maryland 1 Yes 2 X No Anne Arundel Odenton ò 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be by Funeral 1315 Passage Drive 21113 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 X Married 1 X Yes 2 No 1958—
If Yes, Give
Year or Dates. 1962 Baltimore, Maryland 21215-0036 Clarence 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Specify: White 1962 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Technician Cable Television Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John William Simpson injury or other traumatic Beatrice Eleanor Vaughn Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Mary Ann Simpson/Wife 1315 Passage Drive, Odenton, Maryland 21113 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 XI Cremation 3 Removal from State West Arundel 4 ☐ Donation 5 ☐ Other (Specify) Crematory Odenton, Maryland Signature of Funeral Service Ligensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. Will Exone M00672 1411 Annapolis Road, Odenton, Maryland 21113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician) Dneumoni disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) -tran and Due to (or as a consequence of): resulting in death) Last buriatattending physician for use as the burla Physician/Medical that the death certificate be P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Dav Year Yes 2 No the 9 Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed certificate Yes 2 No 2 🗌 No 1 Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Thipatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Suicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completed filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier D71692 June 18,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street, Baltimore, MD 21201 31. Date filed State

DHMH 17 Rev 7/2009

Registrar

19930 State of Maryland / Department of Health and Mental Hygiene U Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Marion Arlene Stackley Month Year 12:30A M 1 2011 Medical <u>June</u> 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Calvert Prince Frederick 1630 Clay Hammond Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)
NY **Funeral** 101-16-8524 1 M 2 XF 93 Months Days Hours Min 7107/1917 Director Usual Residence of Decedent shov 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD Calvert Prince Frederick 1X Yes 2 ☐ No 10f. Zip Code 20678 10g. Citizen of What Country? or 10e. Street and Number 23a Funeral 1630 Clay Hammond Road items ; death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc ō 1 Never Married 2 Married 72 hours after ģ Maryland 21215-0036 If Yes, Give Year or Dates White d Mental Hygiene. marked other than "natural", 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Specify: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Albert Pelow Mae Feeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. Maureen Imwold/Daughter 1630 Clay Hammond Rd., Prince Frederick, MD 20678 t. Page 1 and 2 sl tment of Health a tant. If item 27 is jury or other tra Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/21/2011 Woodbine, MD Final JourneyCrem. 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 Dorota Marshall 5 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 1 Prisaty and Pris Ph_sici_n Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Insulin Dependent Diabetes Mellitus Yes 2 No 3 Probably 4 Unknown been Congestive Heart Failure 24b. Were autopsy findings available prior to completion of cause of death? has performed? Yes 2 No After this certificate 2 🗌 No 1 Yes B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ XNo Other: 읻 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home S Residence 6 Other (Specify) eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29c. License number D 00019427 29d. Date signed (Month, Day, Year) June 17, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anwar Munshi, M.D. 130 Hospital Rd., Prince Frederick, MD 20678 31. Date filed (Month, Day, JUN 2 2 2011 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are; Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dece 2. Date of Death 3. Time of Death Physician/ Medical **Examiner** City, Town, or Location of Death 4c. County of Death Iton 6 timore **Funeral** 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign 3 1 □ M 2 **Z** F Carolina Director 23a or 28a-f shov 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 KYes 2 □ No 1timore 10g. Citizen of What Country? by Funeral 214 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married and Mental Hygiene. is marked other than "natural", or 1 Yes 2 No 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life_DO NOT use retired) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 2 Important; If item 27 is any injury or other trai once. Method of Disposition 20b. Place of Disposition (Name of 5 1 Burial 2 Cremation 4 Donation 5 Other /S 3 Removal from State 5 Other (Specify) Signature Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. the mode of dving, such as cardiac or respiratory arrest. Interval Between Immediate Cause (Final Onset and Death Physician/ ARDIOPULMONARY disease or condition resulting in death) Medical Due to (or as a consequence of). **Examiner** TO Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events CANCER the attending physiclan and hed for use as the burial-transit BREAST To the Hospital or Attending Physician: The law requires that the death certificate be executed METASTATIC Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 2 No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SEMENTIA 1 🗌 Yes 3 Probably 4 Unknown 2 5 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 1 ☐ Yes 2 ☐ No 25. Was case referre to medical examiner?

1 Yes 2 No To Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Man er of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident 3 Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. DO070785 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIMITRA MITSANI BRI N. GUTAW STR. STE 308, BATIMOREUS MA 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 2011 19932

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 16 Year 51 pm **Physician** 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner 399 Local Ave Knollwood Manor Millersville Anne If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 XM 2 □ F Director 230-98-1932 04/09/1959 Maryland Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Funeral Director 28a-f MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò U.S.A. "natural", or items 23a 6658 Shelly Road, 21061 Apt. 183 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No ģ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If them 27 is marked other than "ne any Injury or other traumatic event than "ne once. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Linwood Spidell, Marie Rappold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Terry Miller / Sister 107 N. Bend Terrace, Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Anatomy Gifts Registry | 06/20/2011 | Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Approximate
Interval Between
Onset and Death
NEWOON 23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final **Physician** conolic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐Live birth 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ို 1 TYes 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) FC2153841 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) use of death (Item 23a) (Type, Print) Caliny Drive # 1A Annapales Mid 2007 Tidewater 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

			for State Registrar	State of IV	iaryiano / i		tment of F ficate of E	lealth and Death	,	giene Reg. No		
	Division	/	1. Decedent's Name (First, Mide	dle, Last)					2. Date of De	ath		3. Time of Death
10	Physicia Medic		John W	. Smither	s				J wonth	Ta	9 201	1 01:09 Ам
	Examir	er	4a. Facility Name (if not institution					Location of Death			County of Dea	
-			Baltimore Wash 5. Social Security Number					en Burnie			Anne Ar	
	Funeral Director		215-40-3586	6. Sex 7. Aç	ge (In yrs. last birti 70		If Under 1 Year Months Days	If Under 24 Hrs. Hou <i>r</i> s Min.	8. Date of Bird (Month, Da April	th 30 ^{'ear)} 1	9. Bi 941 Ma :	rthplace (State or Foreign ountry) ryland
	and show at	٥	Usual Residence of Decedent 10a. State 10b. Coun	у	10c. City, Town	or Locat	ion					10d. Inside City Limits
	Aaryla Ba-f tified	Director	Maryland Ann	e Arundel	Glen	Burn	ie					1 ☐ Yes 2 No
	the A	₫	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What C	ountry?
	s 23a	Funeral	100 Albert Dr	ive			21060			US.	A	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 X M 3 □ Widowed 4 □ Divorce	If Van Cive		1	S Decedent of Hises, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	- 1	14. Race - Ame Black, Whit Specif Whit	te, etc.
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Maryland	ntal H ed ot	To B	17. Father's Name (First, Middle	•				18. Mother's Nan	ne <i>(First, Middl</i> e, s R. Lock		Surname)	
Ž	ould build Me Ind Me Ind Me Ind Me Ind Me Ind Me Ind		Russell Smit 19a. Informant's Name/Relation		401	4.4.11	1					
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Jre,	of Hear		20a. Method of Disposition		20b. Place of	Dispositi	on (Name of	!	Date		cation - City o	
<u>E</u>	Page ment ant: If ury or		1 X Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other				ory or other place on Cemet		ປື້ນັກ 23, 2011	Gle	en Burni	.e,MD
Baltimore,	permit. Depart Import any inj once.		21. Signatur of Funeral Service	Ocens //		St		Funeral I				1122201
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	hysician/	W 0	snock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each line		71	Arto	2011	1			Interval Between Onset and Death
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8760	ifficat ng phi as th		IF FEMALE:				-					
x 68	eath certifica attending p	jan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth	of pregnancy 2 Fetal death	3 🗆 E	ctopic pregnancy	V		1 2	23d. Date of de	livery
Box	e deal the at hed fo	Physician/N	1 Yes 2 No	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 🗆 O	ther (specify)				Month	Day Year
P.O.	es that the des signed by the a I be detached i		Part II. Other significant condit	ions contributing to death b	ut not resulting in	n the unde	erlying cause give	en in Part I.	23e. Did to	bacco us	se contribute to	the cause of death?
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ord	v require been si should b	lete	Brain	Emal Hi Anur	elCra	10	1316		24a. Was a	an	24b. Were au	topsy findings available
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al F	sician: The certificate I		25. Was case referred to medica				26. Pla	ce of Death (Chec	1 Yes	2 No	1 ∐ Yes	s 2 XNo
ΧĬ	Physic this ce al direc	2	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ER/Out	tpatient 3	3 □ DOA Other	r: 4 Nursing He	ome 5 🗆 Resid	ence 6	Other (Spec	ify)
o	ding Pr th. After th funeral		27. Manner of Death 1 Manner of Death 5 ☐ Pend	28a. Date of inju (Month, Day		ime of jury	28c. Injury work?	at	28d. Describe h			
ion	tendi death. tor: A the fu	įįįį		igation			M 1 □ Y	Yes 2 □ No				
Division of Vital Records,	I of the hospital of Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	l Certificate:	4 Homicide determ		iry - At home, fari c. (Spec <i>ify)</i>	m, street,	factory, office		28f. Location (S City or Town		Number or Ru	ral Route Number,
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	lo the within 2 To the I comple		only one) 3 Certifyin 29b. Signature and title of certifie	g Nurse Practioner: To the	best of my knowle	edge, deat	h occurred at the	time, date and place	ce, and due to the	cause(s)	and manner as	stated.
	= ≥ 2 8		255. Organization and title of certific		-		29c. License	06AC	19	29d. Date	e signed (Month	
	1 an	ŀ	30. Name and address of person	who completed cause of d	eath (Item 23a) (To	vpe Print	100	20: -		70	ine 2	10011
	, 21		550SE	= 12itch	ie It	igh	way	Broo	Kly	2	MD	21225
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Physic	an	Decedent's Name (First, Middle,		. =				2. Date of Do	eath Da	av Y	oar	Time of Death
/Medi				SR.				June	18	201	1 1	0:50 PM
Examir	er	4a. Facility Name (If not institution,				wn, or Location	on of Death		40	. County of	Death	
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Funeral		5. Social Security Number 219-40-6081	4X N 0 0 0	e (In yrs. last birthda 67 Yrs	Months I	Year If Un Days Hou	der 24 Hrs. rs Min.	8. Date of Bi Month, D. AUG31	rth ay, Year)	/ 0 9	Birthplace Country) MARYL	(State or Foreign
Director		Usual Residence of Decedent		67 Yrs				AUG31	, 19	43	MARYL	AND
land low t		10a. State 10b. County		10c. City, Town or	Location						10d. i	Inside City Limits
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ms 2	Funeral	11. Marital Status	12 Was Decedent 8	Ever in ITS 1			Origin? (Spe	ecify Yes or No			American In	idian.
after or ite		1 Never Married 2 XMarrie		No	Was Deceder If Yes, specify			Rican, etc.)			White, etc.	
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be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest	Education	16a. De	cedent's Usual (Occupation	most of work	ina	16b. h	Kind of Busir		
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2 should and Men is marke aumatic	은		RIDAN, SR.					VIOLA				
12 sh and r		19a. Informant's Name/Relationshi		1	ailing Address (S	Street and Nu	mber or Rura	al Route Numi	er, City	or Town, Sta	te, Zip Cod	e)
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t. Partment		4 Donation 5 Other (Spe		BAYVIE								RYLAND
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lic			1201 D							OME, PA
		23a. Part 1. Enter the diseas, or co	omplications that caused							IMORE		
		shock, or heart failure. List on Immediate Cause (Final	ly one cause on each line	e.	anter the mode (ii aying, sucr	as cardiac (or respiratory a	arrest,		Inte	oroximate rval Between set and Death
Physician /Medical		disease or condition resulting in death)	_a. Seps	15		_						hours
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has age 2	Completed					<u> </u>		auto	osy rmed?	prio	r to comple	tion of cause of
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ysician: The law s certificate has t director, page 2	m	examiner?	Hospital: 1 The hipatier	nt 2 🗆 ER/Outpati	ont 2 DO:	Other:		(Check only o				
ing Physician: I. After this certifica funeral director,	2	27. Manner of Death	28a. Date of Injury			4		ne 5 Resident			Specify)	
ing their	ion:	1 ☑ Natural 5 ☐ Pending	(Month, Day		у 200.	Injury at Work?	"			, occurred		

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funera

State Registrar

Medical Certification

2 Accident 3 🗌 Suicide

4 Homicide

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kristina Froyale, MD

Pending investigation

Could not be determined

29c. License number RES-000

1
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 🗌 Yes

2 🗌 No

29d. Date signed (Month, Day, Year) June 18, 2011

4940 Eastern Avenue, Baltimore, MD, 21224

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SHIRLEY Month 4:45 P M Year Zo | City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, 4001 OLD COURT ROAD #516 4c. County of Death BALTIMORE Baltimore 5. Social Security Number 216-32-0718 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 75 _{Yrs} 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months Days 1271971935 Country) Yrs MD Usual Residence of Decedent 10b. County BALTIMORE 10c. City, Town or Location BALTIMORE 10d. Inside City Limits 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4001 OLD COURT ROAD #516 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KAPLAN **JEAN** CHAIT 19a. Informant's Name/Relationship (Type, P. ALBERT SAVAL/HUSBAND 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 4001 OLD COURT ROAD #516, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place
ARLINGTON CEMETERY
CHIZUK AMUNO 06/17/2011 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208

Pnysician/ Medical Examiner

burial-transit

attending physician for use as the burial

n signed by the a ld be detached f

certificate has

within 24 hours after dearn.

To the Funeral Director: After

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Department of Health ar Important: If item 27 is any injury or other trau

For State Registrar

10a. State

Physician/

Medical

Examiner

Funeral

Director

28a-f show

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Examiner must be

Director

Funeral I

ģ

Completed

Be

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NATHAN

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

2م| Certificate:

29b. Signature and title of certif

<u> </u>		www			, , , , , , , , , , , , , , , , , , , ,		
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	ne cause on each line.			MORNE		Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	a. ENDOME Due to (or as a conseq	TRIAL (ANCER, M	ets		Onset and Death
niner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to or as a context	tioned off:				
cal Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):			:	
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregni 1 Live Birth 2 Fet 4 Pregnant at time of g Unknown	al death 3 🗌 Ectopia			23d. Date of de Month	livery Day Year
ted by PI	Part II. Other significant conditions co		sulting in the underlying	g cause given in Part I.	23e. Did tobacco	1 .	the cause of death?
Comple					24a. Was an autopsy performed?	prior to	topsy findings available completion of cause of
Be	25. Was case referred to medical examiner?			26. Place of Death (Che	ck only one)		
2	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 🗌 I	DOA Other: 4 D Nursing H	lome 5 Residence	6 Other (Spec	ifv)
ficate:	27. Manner of Death Natural 5 Pending Accident Investigation	28a. Date of injury (Month, Day, Year)		28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju		
I Certi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, facto	ry, office	28f. Location (Street a City or Town, State		ral Route Number,
Medical Certificate:	(Check 2 Medical Examin	ician: To the best of my know ner: On the basis of examinatio e Practioner : To the best of m	n and/or investigation, ii	n my opinion, death occurred	at the time, date and place	ce, and due to the	cause(s) and manner stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

June 16, 2011

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAM CONON AD 6569 N. CHANNET ST. BAITHONE, MP 21204

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	Physicia	an/	1. Decedent's Name (First, Middle, Last)	1737			2. Date of Deat	th Day Year	3. Time of Death
	Medi Examir	cal	EMMANUEL O. TETT 4a. Facility Name (if not institution, give street and number		4h City Town or	Location of Death	June	4c. County of Deat	1420M
· .	LXaiiiii	ici	3557 Floating Leaf Lane #		Laure1	Location of Death		Anne Aru	
ı	Funeral Director		578-78-1086 1 [™]	Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec 16	Year) 9. Bir Co	chplace (State or Foreign untry) Ghana
	and show lat	Į.	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl 28a-f otifie	Director	MD Anne Arundel	Laurel					1 ☐ Yes 2🛣 No
	ith the 3a or it be n		10e. Street and Number		10f. Zip Code		1	log. Citizen of What Co	untry?
	ems 2	Funeral	3557 Floating Leaf Lane #	nt Ever in U.S. 13. V	20724 Was Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-	USA 14. Race - Ame	rican Indian
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	۾	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	s? XI No	f Yes, specify Cuba I ☐ Yes 2 🏻 No	n, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
5-0	72 hou "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	dent's Usual Occupa	luring most of worki	na I	16b. Kind of Business	
2121	vithin 7 jene. rr than the M	S	Elementary/Seconday (0-12) College (1-4 c	r 5+) Pro	ONOT use retired). Tessor of	Economic	cs	Bowie Stat	e University
pu	filed val Hyg d othe	Be	17. Father's Name (First, Middle, Last)		operator-	18. Mother's Name			
yla	uld be I Ment narke	٩	Daniel Tettey			Gladys (
Mai	2 sholuth and 27 is not traum		19a. Informant's Name/Relationship (Type, Print) Samuel Quartey - Uncle	19b. Mailin				City or Town, State, Zip	Code)
ē,	1 and of Heal item other		20a. Method of Disposition	20b. Place of Dispo-	stwood Co	Г	orhees,	NJ 08043 20c. Location - City or	Town, State
<u>=</u>	Page nent o ant: If ury or		1 ☐ Burlal 2 🖾 Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	te Metropoli	natory or other place tan Crema	1		Alexandria	
Baltimore,	permit. Departimport Import any inj		21. Signature of Funeral Service Licensee	2 M	arshal I-M		eral Hom	e of Maryl	and
ı			23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause in each li	ed the death. Do not ente	er the mode of dying	, such as cardiac o	r respiratory arres	st,	Approximate Interval Between
	Pnysician/ Medical	į.	Immediate Cause (Final disease or condition resulting in death)	erio sche	rotia	FEART	1013	CASE	Onset and Death
	Examiner		Dus tr (or a	s a consequence of):	5100				
		iner	if any, leading to immediate cause. Enter Underlying	a consequence of):	320.4				
	ecuted and transi	Examiner	Cause (Disease or iinjury that initiated events c.	a betes	-				
0	icate be executed physician and sthe burial-transit	ledical E	Chr	once f	Zena 1	(FAI	/lur-	-	
8760			IF FEMALE:						
. Box 68	The law requires that the derth certifics ate has been signed by the rending page 2 should be detached or use as the contract of the contract	Physician/N	23b. Was decedent pregnant 23c. If yes, outcome in the past 12 months? 1 ☐ Live Birth	n 2 🗌 Fetal death 3 🗀 at time of death 5 🗀	Ectopic pregnancy Other (specify)	/		23d. Date of deli Month	very Day Year
s, P.O.	requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death	but not resulting in the ur	nderlying cause give	en in Part I.		acco use contribute to	the cause of death?
ord	aw requasis been 2 shoul	Completed					24a. Was an	24b. Were aut	opsy findings available
Rec	The law ate has page 2:	Som		7.		·	autopsy perform	ned? death?	ompletion of cause of
ta	ysician: The is certificate director, pag	Be (25. Was case referred to medical examiner?			ce of Death (Check		12 103	2 0 110
<u>></u>	Physic rthis o	<u>:</u> ک	1 Yes 2 □ No Hospital: 1 □ Inpa 27. Manner of Death 28a. Date of in	itient 2 ER/Outpatient	t 3 DOA Other	4 L Nursing Hor		nce 6 Other (Speci	(y)
ono	nding ath. r; Afte ie fune	icate	1 Natural 5 Pending (Month, D		work?		od. Describe nov	v injury occurred	
Division of Vital Records,	or Atte	Certificate:		njury - At home, farm, stre tc. (Specify)	et, factory, office	2	28f. Location (Stre	eet and Number or Run State)	al Route Number,
	ipital o								
3	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the best of Check 2 Medical Examiner: On the basis of Check only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier	examination and/or investi-	gation, in my opinior eath occurred at the	n, death occurred at time, date and place	the time, date and e, and due to the c	place, and due to the c ause(s) and manner as	ause(s) and manner stated.
D	6 ≥ 6 8		William PA	5 mo	29c. License	0605	29	d. Date signed (Month)	Pay, Year)
	- 0		William P. JoNE	death (Item 23a) (Type, Pr	695	Am	erica	2103	5
	State Registra	_	31. Date filed (Month, Day, Year) 32. Regist 32. Regist	rar's Signature					

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 SEBASTIAN NICHOLAS ULSCH, JUNE 17 $12:30A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death LOCH RAVEN C.L.C. BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 - F Days Min. Hours APR1 **Director** MARYLAND <u>217-38-5928</u> 70 Usual Residence of Decedent 28a-f shov 10a. State 10b. County must be notified at 10c. City, Town or Location the Maryland Director 10d. Inside City Limits MD. HARFORD ABINGDON 1 Yes 2 No 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? Funeral **23**a 3439 HENRY HARFORD DRIVE 21009 U.S.A. items ? . Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Farti frem 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner muliny or other traumatic event, the Medical Examiner muling or other traumatic event, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) STATE OF MARYLAND 12TH CAMPUS POLICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 SEBASTIAN NICHOLAS ULSCH SOPHIE LEPKOWSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, CAROL ANN ULSCH /WIFE 3439 HENRY HARFORD DRIVE ABINGDON, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1
Department of important: If it any injury or o JUNE 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) BAYVIEW CREMATORY! 21, 2011 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenseq 22. Name and Address of Facility $KACZOROWSKI\ FUNERAL\ HOME, PA$ TWhi 1201 DUNDALK AVENUE BALTIMORE, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death CARCINOMA OF LUNG disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live Birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 AN 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 X No Other: မ 1 🛚 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No death. Accident Investigation 6 Could not be 24 hours after deatle Funeral Director. Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗖 To the Within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of Sertifier D36508 7071 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHA 6x11 2/2 MI 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#/perfil, G916,6/28/2011, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Herbert Washington Willingham, Jr. 20, 2011 June 12:45 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 134 Olen Drive Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☑ M 2 ☐ F 213-26-5664 **Director** 80 Dec. 5, 1930 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, it is Medical Evanmer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo MDAnne Arundel Glen Burnie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 134 Olen Drive Funeral 21061 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 🔀 No Specify. White þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Freight 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Washington Willingham Vergie V. Bach 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important; If item 27 is
any Injury or other trau 134 Olen Drive; Glen Burnie, MD 21061 Ken Willingham-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Baltimore Wash.Crem. 6/22/2011 Laurel, MD 4☐Qonation 5☐Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Dignature of Funeral Service Licenses 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SteoSarCon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-trans nen Due to (or as a consequence of) Physician/Medical After this certificate has been signed by the attending properal director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home SResidence 6 Other (Specify) No No Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitan w. within 24 hours after death.
To the Funeral Director: Aftramorately filled in by the fur Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00066019

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Tamad

Mira MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month June Bernett Watkins Medical 4:55A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Randallstown 4c. County of Death Seasons Hospice Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)
 T7A 1 □ M 2 🗶 F Months Days Hours 4-2-1925 Year) 219-18-7605 Director VA Usual Residence of Decedent 28a-f shov 10a. State with the Maryland Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 ☐ Yes 2 🄀 No Gwynn Oak ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2114 Meadowiew Drive 21207 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Completed by 1 Never Married 2 Married Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Specify: African-American 1 Tes 2 No Specify: 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ *a*wrence Nutt Florence Holden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2114 Meadowiew Drive, Gwynn Oak, MD 21207 Rene Pritchett/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Dulaney Valley 1X Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 6-24-2011 Timonium, MD Signal eral Service Licen 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atheroscientic lardi ovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of): ≓xaminer Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 as the b IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death Day Year 9 Unknown Unknown P.O. 1 þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, cate has been sig ; page 2 should t Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) 6 Mother (Specify) မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Descripting Projects: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) MS Rijapahse M.D D0057465 6/19/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 2835 5 min Av. 5-203 N S Kaja pakse, M. P 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-9960 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Raymond Widerman Sr. 06 2011 21:20 p^M 16 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Mar 1^{Day,} 19955 . Age (In vrs. last birthday **Funeral** 9. Birthplace (State or Foreign 1 ▼ M 2 □ F Months Hours Director 217-62-0701 56 Vrs Country) MD Usual Residence of Decedent works, 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f MD Carrol1 Sykesville 1 ☐ Yes 2X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral 1107 Liberty Road 21784 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian med Forces?

Yes 2 No Black, White, etc. Armed Forces:
12 Yes 2 No
If Yes, Give
Year or Dates. 1972-75 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Divorced 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Walter Newton Widerman, Jr. Shirley Ann Tasker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1107 Liberty Road, Sykesville, MD 21784 Mrs. Sue Widerman (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 6/21/2011 Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee MO0764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician metestate melaren disease or condition 6 month Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Due to (or as a consequence of, If any, leading to immediate cause. Enter Underlying Examin Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day 1 Yes 2 No Year ed by the a g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? ۵ م coronary ortery diverse 1 🖎 Yes 2 🗌 No 3 🗌 Probably 4 🗀 Unknown Completed Chronic obstructure pulmonary discover 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performe 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🔼 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE funeral, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred or Attending 1 🖺 Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No the f ☐ Accident Investigation 6 Could not be 3
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Richards Borg (4) 20020604 hazland 6/17/11

DHMH 17 Rev 7/2009

State Registrar Richard A. Bergino ; 2700 Quary Lake Drive, Bullinose, and 21200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
JUN 2 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Carl Willett 2011 James June 12:56P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🛛 M 2 🗆 Months Days Hours (Month Day Year) 42 Director 220-38-3383 69 Maryland Usual Residence of Decedent 28a-f show 10a. State ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince Georges Capital Heights 10e. Street and Number 10g. Citizen of What Country? Funeral 505 Hampton Park Blvd., Ste. E 20743 U.S.A. hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1

Yes 2 □ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. þ 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 Divorced 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 9 Handyman Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Willett Robert Carrie L. Atckinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Lydia Simpson / Care Provider <u> 3105 Hampton Farm Lane, Brandywine, MD 20613</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Anatomy Gifts Registry 06/20/2011 Hanover, Maryland Signature of Fuperal Service License 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M 4001241 Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Stirm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 E FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ō Dav Year Pregnant at time of death Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performed/? Yes 2 Z No Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) J V 06/19/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** June 17, 2011 6:10am Samue1 Eugene Zahn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Golden Living Carrol1 Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year)
Nov 28, 1915 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F Yrs. 95 Director MD 217-18-8394 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner rust be notified at 1 Yes 2 No Director Carrol1 Westminster 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Items 23a 510 Treemont Drive, Apt. 21157 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: White þ 3 Widowed 4 Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If them 27 is marked other that any injury or other traumatic event 4 Estate Caretaker **Agriculture** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Luther Zahn Bertha Shipley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Regina F. Zahn (Spouse) 510 Treemont Drive Apt. 1 Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Lake View Mem. Park 6/21/2011 Sykesville 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Sugn 10076 PO Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician crelivorascula /Medical Due to for as a consequence of): Examiner iringelis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed burial-transit -Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy or in the past 12 months? Month Day Year 4□ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy perform 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending death. investigation 1 🔲 Yes 2 No Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours To the Funerel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certific 29d Date signed (Month Day Year 29c. License number 30. Nan nd address of person who Registrar

DHMH 17 Rev 7/2009

11-04392	
Frron M. Bates	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 1

Erron M. Bates		1- For State	ate of Maryla	C-4:6	nent of cate of		Mental Hy	J	h 0 1	1 1994
Physicia Medical Exami	ın/	Registrar Amend#8 Per 1. Decedent's Name (First, Middle	Last)	JIU R	atc	S		2. Date of Death Month June 11, 2	Day Year	3. Time of Death 0839 hrs
•		4a. Facility Name (if not institution Prince Georges Hospit	. •	nber)	4t	City, Town, or L Cheverly	ocation of Death	· · · · ·	4c. County of De	
Funeral Director		E77-98-1002	5. Sex	7. Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birt		Birthplace (State or eign
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	-	n ,		200		10d. Inside City Limits
Maryland 28a-f show	Director	10e. Street and Number	4_	2	ask	10f. Zip Code	0	10	g. Citizen of What Co	1 Kes 2 No
eath with the Maryland riems 23a or 28a-f sho ust be notified at once.		809 55 11. Marital Status	Str.	cct (UE 13. Was	2 Decedent of Hispa	0019	ecify Yes or No-	U.S.	erican Indian, Black,
after death v ul", or item	by Funeral	1 Never Married 2 Mar			If Yes	, specify Cuban, I			White, etc.	ack,
2 hour	Completed b	15. Decedent's Education (Speci Elementary/Secondary (0-12)				Usual Occupation to of working life. D			16b. Kind of Busines	s/Industry
D 21215-0036 should be filed within 72 hou and Mental Hygiene. 7 is marked other than "nat natic event, the Medical Exa	o Be Cor	17. Father's Name (First, Middle, L	Bat	es aktor It	9b. Mailing A	l	Mother's Name	DID,	aiden Surname)	on Mitche
nore, MD 2 ages I and 2 shou nt of Health and nt f: If item 27 is and other traumatic		Marcia Middelte 20a, Method of Disposition	on-MIEC	20b. Place	127 J	on (Name of ceme	Street			DC 20017
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other the		1 Burial 2 Cremation 4 Donation 5 Other Spe 21, Sig ture of Funeral Service L	cify:	n State For		ne and Address o				el Home
Physician /Medical	1	23a. Part I. Enter the disease, or confailure. List only one cause of	omplications that cause a cach line. Caro	used the death. Do r liac Arryt	not enter the	mode of dying, su associat	ich as cardiac or	respiratory arres	st. shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a.complica Due to (or as a c	ating chro						Death
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a c							
	dical Exa	events resulting in death) Last	Due to (or as a c			10 0 0 1	1			
760, ficate be e.g physician	/Medic	X UNPENDED F FEMALE: 3b. Was decedent pregnant in the	23c. If yes, ou	Ba, 27, per	,		1		23d. Date of delive	•
Box 68 e death certi	Physician/Me	past 12 months? 1 Yes 2 No 9 Unkno	9 Unknow	nt at time of death		death 3	Ectopic pregnan	cy 	Month	Day Year
F, P.O.	2	Part II. Other significant condition	s contributing to c	leath but not resultir	ng in the und	erlying cause give	en in Part I.			o the cause of death? obably 4 ✔ Unknown
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate t within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu	Completed							24a. Was ar autopsy perform 1 ✓ Yes 2	prior to death?	
/ital sician: is certif	8	25. Was case referred to medical examiner?	Hospital: 1	patient 2 🗸 ER/C	Outpatient 3		Death (Check or	lly one) Home 5 R	esidence 6 Otho	or:
lon of \ tending Phy eath. or: After the funeral	ation: To	1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pending 2 Accident Investig	28a. Date of (Month, D	Injury 28b.	Time of Inju	ry 28c. Injury a			w injury occurred	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Ę	3 Suicide 6 Could r	ot be 28e. Place of	of Injury - At home, f	arm, street, f	actory, office build	ding, etc. 2	8f. Location (Str or Town, Sta		ural Route Number, City
To the Hos within 24 h To the Fun completely	edical	one) 2 Medical Exami		examination and/or i					s) and manner as sta id place, and due to t	
0 1 3	₹ 2	29b. Signature and title of certifier	1. 1	& TR. 11	4.μ	29c. License n	DOM	=	29d. Date signed <i>(Me</i> June 12, 2011	onth, Day, Year)
15 On low		0. Name and address of person with Theodore M. King, Jr., N		of death (Item 23a) t Medical Exam	iner 90	0 W. Baltimor	e Street, Bal	timore, MD	21223	
Sta Registra	te ³ ar	1. Date filed (Month, Day Year)	32. Regis	strar's Signature	ري					
DHMH 17 Rev 1/200 OCME 2006				OR	RIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 2. Date of Death nt's Name (First, Middle, Last) 3. Time of Death Physician/ 31PM 201 Medical , give street and number) **Examiner** inty of Death Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min Country) Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2 ☐**X**lo Maryland Charles Nanjemoy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2810 Sunny View Place 20662 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married "natural", or 2 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 🗌 Widowed 4 🗆 Divorced Year or Dates and Mental Hygiene.

is marked other than "naturaumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Homemaker Her Home 0 permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Aurella Minnix Sherman Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8780 Riverside Road, Nanjemoy, Md. 20662 Lorene Freeman Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place une 13, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Nanjemoy Baptist Church Nanjemoy, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Serv Williams Funeral Home.P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 23a. Part 1. Enter the disease, or complications that caused shock, or lear failure. List only one cause on each line he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine as been signed by the attending physician and 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available After this certificate has prior to completion of cause of death? autopsy page 1 Yes 25. Was case referred to medica completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 **X**No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) work? 5 Pending within 24 hours after death. To the Funeral Director: A 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, 06/06 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1134 Dr. Jos jin Vanhappilly strar's Signature State JUN 0 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 June 6:30 P^{M} Nancy Virginia Brandenburg Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day, Year) Aug. 6, 1946 If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 6. Sex 9. Birthplace (State or Foreign 1 🗌 M 2 🔀 F Months Days Hours Maryland Director 219-44-4514 64 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Frederick Maryland Frederick 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21702 United States 2501 Catoctin Court Unit #3A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🏝 No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural" 3 Divorced 4 Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Office Manager Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Preston Leroy Moats Maude Catherine Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Richard T. Brandenburg/Husband 2501 Catoctin Court Unit #3A Frederick, Maryland injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 6/8/2011 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland. Resthaven Memorial Gardens 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 21. Signature of Funeral Se Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Retween Sel Onset and Death immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** רתטלטת Sequentially list conditions, Examine if an leadin to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and I-transit Due to (or as a consequence of physician are the burial-t resulting in death) Last Physician/Medical death certificate be Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔀 No Dav Pregnant at time of death 1 Yes 2 9 Unknown q Unknown P.0. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page 1 ☐ Yes 2 ☐ No Yes 2 X No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital Other: 1 Yes 2 X No မှ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending neral Director: Aft 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I only one) 29b. Signature and title of certifier 29c. License number MOD 6-4-2011 achima Ubnoles 64910 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) trederick, mo 21701 Pander 400 Pratima W

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

backer

ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 19947 State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month РМ Helen M. Beck 2011 Medical June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House <u>Mount</u> 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕇 F Months Hours Director 11706/1927 Country) Yrs. 174-24-1278 83 PA Usual Residence of Decedent or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10a. State 10b. County injury or other traumatic event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🏋 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5655 Etzler Road 21702 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) administrative assistant education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Vernon C. Mack Elsie Hester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl Beck/husband 5655 Etzler Road, Frederick, MD 21702 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gar. 6/8/2011 Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. shock, or heart failure, List Onset and Deat Immediate Cause (Final CARCINOMA OF THE BREAST NUCTAL Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or impury that initiated execute. Examine Due to (or as a consequence of). The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death the a 9 Unknow signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 200 completed filled in by the funeral director, page 2 should 3 Probably 4 Unknown peen 24a. Was an Were autopsy findings available prior to completion of cause of • Hospital or Attending Physician: The law a 24 hours after death.
• Funeral Director: After this certificate has t autopsy perforr death? 1 🗌 Yes 2 No ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence HOUSE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License numbe 031761 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 O'CONNOR 501 W. SEVENTST., FREDERICK MD BRIAN M. MA 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 19948 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 Month CHARLES RAYMOND BROWNLEY June 3:29 AM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 **X** M 2 □ I 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 4/27/193] Hours Min. 218-26-0632 Maryland **Director** 80 Usual Residence of Decedent 28a-f show 10a. State 10b. County of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD. 1 Yes 2 No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral #430 #403 1819 Selvin Drive 21015 United States 12. Was Decedent Ever in U.S.
Avmed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 20.0329.000~6/15/8Baltimore, Maryland 21215-0036 þ 1 Never Married 2 Married 1 Yes 2X No Specify. 3 Widowed 4 Divorced Completed White Korea Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) United States Elementary/Seconday (0-12) College (1-4 or 5+) Civil Engineer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Almira Raymond Brownley Blanche McCaffrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21015 Important: If item 27 any injury or other tra Pebble Brownley (Wife) 1819 Selvin Drive #403 Bel Air, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 24. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Mem. Gardens 2011 Fallston, Maryland of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Hackten Jarrettsville, Maryland Home. P.A. 23a. Part 1. Enter the disease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Dissociation Blecho maenchic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner COVORCE Preny Discore Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Brownky, Charle Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Year 4 ☐ Pregnant at time of death g ☐ Unknown 1 ☐ Yes 2★ 9 ☐ Unknown signed by the a Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 2 🗌 No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 2 🗌 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide within 24 hours after death

To the Funeral Director: A
COMPLETE OF THE FUNERAL STATES O Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) S. Ragioraj. 0053720 06/15/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RO Belowir, MD 21015 c. Raguraj mo 208-C PLOEMTICE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 2 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 9949 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ leman 7:30 A M . Medical City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death radiford Oaks Nursing noton If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign **1X** M 2 □ F Months Days Hours Min. Director Usual Residence of Decedent 28a-f shov 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Den Meadre Ave 20744 ISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Was Deceuent Armed Forces? 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 ☐ Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) stodian Be Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) ပ္ iMa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Den Meade Aue-Ft Washington MD 20744 oleman Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 06/13/2011 Abexandria, NA 21. Signature of Funeral Service License 22. Name and Address of Facility Greene Funeral Home nelson & Green Alexandria, VA 22314 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each inc. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence on). sician and burial-transit resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Dav Year Pregnant at time of death Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₫ Division of Vital Records, 2 No Completed 1 Yes 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 No certificate 1 Yes 2 No Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify this 27. Manuar of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. I Director: After t Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury 1 Yes 2 No Accident Investigation 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified License number 29d. Date signed (Month, Day, Year) s who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per-31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Arthur Α. Colbert 12:40P M 06 Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Chever1y Prince George's Social Security Number If Under 1 Year **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Min Hours 07 1 1 Director 219-34-8550 1938 72 DC Usual Residence of Decedent shov 10a. State with the Maryland items 23a or 28a-f sho her must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's MD 1X Yes 2 □ No Springdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3519 Edwards Street 20774 USA death 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. traumatic event, the Medical Examiner 1961 If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1963 1 ☐ Yes 2X No Specify: If Yes, Give 'natural", Completed 3 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Float Builder Hargrove Incorporated Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Floyd C. Colbert Martha Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a tant: If item 27 is Ruth Colbert/Wife 3519 Edwards St. Springdale, MD 20774 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 06/10/2011 Clinton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home of MD 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Atherosclerotic Cardiovascular Disease Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami and trar resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Day Month Year by the stached Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Rectal Carcinoma 1 Yes 2 No 3 Probably 4 L Unknown 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 No death? certificate | 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 🕅 No 2 1 Inpatient 2 XER/Outpatient 3 I DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes Accident I Director: / Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed To the I within 2. 29b. Signature and title of certif 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Griffin L. Davis, 3001 Hospital Drive Cheverly, MD 20785 M/

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUN U B ZU11

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stevie Carter Month 00:35 M Medical 06 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Baltimore, BALTI.CITY Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth 578-88-4867 1**x** M 2 □ F Hours Min. WASH D.C. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD. PRINCE GEORGES ACCOKEEK 1 ☐ Yes 2 X No 10e. Street and Number ь 10f, Zip Code 10g. Citizen of What Country? Funeral 16712 LIVINGSTON ROAD 20607 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Completed by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 Specify: BLACK If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: "natural", 3 Divorced 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I.R.S. Elementary/Seconday (0-12) College (1-4 or 5+) LIBRARY TECHNICIAN 12 U.S.GOVT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental 2 JIMMY CARTER JANNETTE BLOUNT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16712 LIVINGSTON RD. ACCOKEEK, MD. 20607 LACY CARTER-SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State HERITAGE MEM. CEM. 6-20-11 WALDORF, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MQ-0479 LA PLATA, MARYLAND 20646, P.A. lu 23a. Part 1. Enter the disease, or complications that caused the death. Do not at the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Enc S+a 1

Due to (or as a conse unce of): Liver Disease inknown disease or condition Medical resulting in death) Examiner Diseas unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence on Examir Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day 1 Yes 2 No q | Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 👿 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🛣 No Other: 1 M Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 🔀 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending nours after death.

neral Director: Aff
filled in by the fur Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined building, etc. (Specify) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number P24327 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greine Street. Baltimore MD 21210 rochmal 31. Date filed (Month, Day, Year) 32. Registrar's Signature State IIIN 2 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10045 Jaw JUNE 2011 1:45A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GENESIS WALDORF HEALTH CARE WALDORF CHARLES 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Hours 1 □ M 2 😾 F MAR . 9 , 1914 243-05-1047 N. CAROLINA Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland items 23a or 28a-f sho her must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes XXNo CHARLES BRYANTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6650 LEONARDTOWN ROAD 20617 S. A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 Specify:WHITE 1 ☐ Yes 2 X No Specify: "natural", 3 V Widowed 4 ☐ Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 HOMEMAKER AT HOME Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental | permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marter any injury over 2 BAXTER MONROE GIBSON DOVIE GLOVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH T. CRAWFORD/SON 1004 SPRUCE STREET WALDORF, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 6-21-11 FT.LINCOLN CEM. BRENTWOOD, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 on M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Dav Year 2 No has been signed by the a should be detached 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury Accident 5 Pending work? 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined building, etc. (Specify) within 24 hours To the Funeral Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 71199. 06 gn 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Brine 1A

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last), 2. Date of Death 3. Time of Death Month Year 1.12 DVISCOLL ouise June 2 2011 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Gr county GIVOW Medical Andrews AFE Malcolm center If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 □ M 2 1 F Months 579-12-3996 Virgínia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits District of Columbia Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1211 34th Pl., S.E. 20019 USA 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ^{Specify:}American 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Director Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Alton Roberta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) Vera Lynne Thomas 3366 Curtis Dr., Apt. 103, Suitland, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial 06/15/2011 Suitland, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Jordan Funeral Service, Inc. 21. Signature of Funeral Sept 4001 Benning Rd., N.E., Washington, DC 20019 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 0000 Due to (or as a consequence of): thera DeuTic days Su Der Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque ce of): Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? monari 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2- No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 npatient 2 ER/Outpatient 3 DOA 1. Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🗀 Natural 5 Pending

or Attending Physician: The law requires that the death certificate be executed and physician a s the burial-P.O. Box 68760. as attending p by the a Division of Vital Records. as been si Jas page certificate funeral director After death. hours after deatl uneral Director: filled in by

Examine Physiclan/Medical à Completed Be ٩

Certification:

Physician

Examiner

Funeral

Director

28a-f show

Itema 23a or

5

"natural"

other than

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event size.

Physician /Medical

Examiner

the Medical Examiner must be notified at

Director

Funeral

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Completed

Be

the Maryland

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

/Medical

within 24 hours a

To the Funeral C

completely filled i

Hospital

Medical 29b. Signature and title of certifier

(Check only one)

2 Accident

3 Suicide

29a. Certifier

31. Date filed (Month, Day, Year) JUN 0 8 2011

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 XNo

29d. Date signed (Month, Day, Year)

all

34th PL

28f. Location (Street and Number or Rural Route Number, City or Town, State)

0101237592

1211

June 2011

D.C.

30. Name and address at person who completed cause of death (Item 23a) (Type, Print)

investigation

6 Could not be determined

Clint Hoangquocgia MD 1050 W.Perimeter Rd. AAFB Md. 20762

31 2011

State

Registrar

unknown

Home

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Catherine Lavonne Dow June 7, 2011 а м 9:15 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 4835 Smallwood Church Rd. Indian Head Charles . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🗆 M 2 💢 F Days Hours Min. (Month, Day, Year) Yrs Director 279-28-0499 26, West Virginia 1930 Usual Residence of Decede 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Charles Indian Head ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 4835 Smallwood Church Rd. 20640 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 ☐ Xo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify Specify: White "natural" 3 Widowed 4 Divorced Completed Year or Dates er than "natur, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) uth and Mental Hygiene.
27 is marked other than r traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+) Secretary U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Arnold A. Kellar Catherine V. Lyden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. 4835 Smallwood Church Rd., Indian Head, Md. 20640 John Dow Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 8, 2011 1 🗆 Burial 2 🗚 remation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Alexandria, Virginia <u> Metropolitan Funeral Service</u> 22. Name and Address of Facility
Williams Funeral Home, P.A. ire of Funeral Service Lic M00668 4270 Hawthorne Rd., Indian Head, Md 20640 23a. Part 1. Enter the disease, or complications that caused shock, or hear failure. List only one cause on each line disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ OV Pal Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any country cause. Enter Underlying Due to (unes a consequence of) Exami I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): as the bunal the attending physician thed for use as the bunal Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month detached sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death?

1 Yes 2 No certificate To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 V No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deal 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No -Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State

JUBS

30. Name and address of person

31. Date filed (Month, Day, Year)

0

JUN 0

who completed cause of death (Item 23a) (Type, Print)

distrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month UBERT Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3913 West Shore Drive Edgewater Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth March 2 If Under 1 Year Funeral 9. Birthplace (State or Foreign Day Year 1 M 2 D F Months Days Hours New York Director 084-18-0677 86 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f shoi jury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Maryland Anne Arundel 1 ☐ Yes 2 🌠 No Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3913 West Shore Drive 21037 USA 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Force Black, White, etc. ģ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify Year or Dates. 1942-70 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Naval Officer U.S. Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Seymour Dredger Loretta O'Brien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Dredger/ Son permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 3913 West Shore Drive, Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Natl. Cem.: 10/3/11 Arlington, Virginia 21. Signature 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence oi): Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and a be detached for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Year Dav 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 4 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 🗌 Yes 2 Accident
3 Suicide
4 Homicide 2 🗌 No within 24 hours after death

To the Funeral Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 1 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month) U 51 ompleted cause of death (Item 23a) (Type, Print) 30. Name and address of person luy. ANNAPOLIS MUZYO CAMP. 10R 31. Date filed (Month, Day JUN 07 Registrar's Signature

State Registrar

			For State Registrar	State of Ma	Cei	rtificate of			Reg. No.	
	Dhysisi		1. Decedent's Name (First, Middle, Last					2. Date of Dea Month	Day Year	3. Time of Death 8:30P M
	Physici /Medic	_	Dorothy Lee Decke					June	3 2011	
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of De	
			105 West "C" Stre 5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	h 9 Bi	irthplace (State or Foreign
	Funeral Director			M 20%F	96 Yrs.	Months Days	Hours Min.	July I	1914 Fre	derick Cty M
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Many -1 sh	ţō	MD Freder	ick	Brunswi	ck				1 XYes 2 No
	with the	i Direc	10e. Street and Number 105 West "C" Stre	et		10f. Zip Code 2171	16		10g. Citizen of What C USA	country?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		
Ö	72 ho	ted	15. Decedent's Edi (Specify only highest grad	ucation	16a. Dece	dent's Usual Occup	pation during most of work	ina	16b. Kind of Busines	s/Industry
21	thin ie.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		during most of work d)		Homemaker	
2	filed wi Hygien other th	Co	12			Housewife		151-4 Adidda	Maiden Sumame)	
and and	be fil ntal H ed ott	Be	17. Father's Name (First, Middle, Last) Philip Tilghman E	werhart			Melva Oc:		·	
ž	2 should be and Menl	٢	19a, Informant's Name/Relationship (T		10h Maili	na Addrage (Street	<u></u>		r, City or Town, State,	Zin Code)
Za	d 2 sl th an t7 is r traur		Barbara Decker, I			•			•	
ē	Health Health tem 27		20a. Method of Disposition		20b. Place of Dispo			Date	20c. Location - City of	or Town, State
Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of Heali Important; if item 2 any injury or other 2008.		1 ☐ Burial 2 ☑ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify)	Hagersto	wn Cremat	ory 6/6/		Hagerstown	ı, MD
Ba	Depar Impor any in		21. Signature of Funeral Service Licens	lan	J	ohn T. W 00 Peters	illiams Fu sville Ro	uneral B ad, Bru	Home nswick, MD	21716 Approximate
60,	Care be executed by Medical Examiner By physician and as the burial-transit	al Examiner	23a. Part1. Enter the disease, or come shock, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c.	Hype	utens				Interval Batween Onset and Death
, P.O. Box 68760,	the death certify y the attending Iched for use a	by Physician/Medical	230. Was decedent pregnant in the past 12 months? 1 Yes 2 Who 9 Unknown Part II. Other significant conditions co	4 ☐ Pregnant at 9 ☐ Unknown ontributing to death b	2 Fetal death 3 time of death 5 time of death 5 time of death 5 time of the tut not resulting in the tut			23e. Did to	23d. Date of d Month	lelivery Day Year to the cause of death?
rds	quire: in sign uld be	d b	Bherosch	evotie a	LRear	<u> </u>		10	res 20No 3□	Probably 4 □Unknown
Division of Vital Records,	The law requires that ate has been signed b page 2 should be deta	Completed			,			24a. Was autop perfo 1 🗆 Yes	prior to the second sec	autopsy findings available o completion of cause of ? es 2 \(\) No
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only o	ne)	
7	Physician: this certific ral director,	မ	1 ☐ Yes 2 No.	Hospital: 1 ☐ Inpatie		nt 3 DOA	ner: 4 🗆 Nursing Ho		dence 6 Other (Sp	pecity)
n c	ing P	ion:	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry Year) 28b. Time of Injury	Wo	ry at rk?]Yes 2 □No	28d. Describe i	now injury occurred	
ivisio	il or Attending after death. I Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ury - At home, farm, st c. (Specity)		1162 5 140	28f. Location (S City or Tox	Street and Number or wn, State)	Rural Route Number,
Ω	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical Ce							cause(s) and manner date and place, and d	
	To the h within 24 To the F complete	Med	one)	and manner sta		29c Licen	se number		29d. Date signed (Mo	nth. Dav. Year)
	To To		29b. Signature and title of certifier	1		D	47169		6161	2011
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	5		30. Name and address of person who come and address of person who	Ho M	lan (nem 23a) (1ype	ath	ANG BU	74481407	29d. Date signed (Mo	21716
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	1	1100 471	V ~ 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	/	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State 9957 Certificate of Death No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ eanne Elizabeth Medical 0848 AM 2011 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death Frederick Homewood at Crumland Farms Frederick, maryland Social Security Number T-0.D: 0848 9. Birthplace (State or Foreign Country)
Vermont **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 □ M 2 👿 F Hours Director 87 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location notified at Director 10d. Inside City Limits 28a-f MD Frederick Frederick 1 XYes 2 No 10e. Street and Number ō 10f. Zip Code er than "natural", or items 23a or the Medical Examiner must be 10g. Citizen of What Country? Funeral 7407 Willow Road 21702 United States 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Black, White, etc þ 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 ♥ Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker and Mental Hygie is marked other Own Home injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Matthew Higgins Elizabeth Lassor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Erin Martin / daughter 2402 Steepleview Ct., Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Cremation 3 Removal from State Smithsburg Crematory 6/17/2011 Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home perfeller /he MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ph_sici_n Onset and Death disease or condition Due t (or as a consequence of): Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate Cause (Disease or iinjury that initiated events Jementia Due to (or as a consequence of): resulting in death) Last Physician/Medical SCONNE IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month 9 Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hospital or Attending Physician: The law I 24a. Was an performed Yes 2 X No Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) of Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural **Division** 5 Pending injury 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Scertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wolfe 300 W. Outh fredericle MD 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

11-04055 Sean Oneil Ellis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legib	ole ,	1	10
State of Maryland / Department of Health and Mental Hygiene	ZUI		13

		1- For State Registrar		Cei	rtificate of	Death		F	Reg. No.		
Physicia Medical Exami		1. Decedent's Name (First, Midd						Date of Dea Month		ear	3. Time of Death
iviedicai Exami	ner	Sean Oneil 4a. Facility Name (if not institution				0.0.2		May 31, 2	2011		0011 hrs
		1306 Rollins Avenue	on, give street and n	umber)	ľ	b. City, Town, or L Capitol Heigl		h	4c. Count	y of Death George	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast hirthday)	If Under 1 Year	If Under 24Hi	s 18 Date of Bi			thplace (State or
Director		579-13-7317	1XM 2_F	24		Months Days	Hours Mi	2		Foreig	m Wash. DC
_		Usual Residence of Decedent	1 A M 2 F		Yrs.			9/1/	/1986	Co	untry)
Any		10a. State 10b. County		10c. City,	Town or Location	on -					10d. Inside City Limits
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he M	Director	1901 Colett	e Terrac	re e		20747			USA		•
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. tem 27 is marked other than "natural", or items 23s or 23s-f shortramatic event, the Medical Examiner must be notified at once.		11. Marital Status		cedent Ever in U.		Decedent of Hisp	anic Origin? (S	pecify Yes or No		ce - Ameri	can Indian, Black,
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ours a	ᅙ	15. Decedent's Education (Spe		de completed)		's Usual Occupatio			16b. Kind of I	Business/I	ndustry
6 172 h cal E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		st of working life. [JO NOT use re	urea)			
youthin within iene.	틹	12			dea	aler					ıstry
15-00 filed wit I Hygien d other	ပ္ဆု	17. Father's Name (First, Middle				18	3.Mother's Nam	e (First, Middle,	Maiden Surnan	ne)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	8	Clarence O		llis	10h Mailing	Address (Chart	Charl	ene Mo	cKelvi	n	Zip Code) 20747
MD 2 nd 2 shou uith and h m 27 is n aumatic	은	Charlene McK		other	11001	Colotte	and Number or	Rurai Route Nur	nber, City or To	wn, State,	^{Zip Code)} 20747
e, M l and 2 Health item 2	H	20a. Method of Disposition	CIVIII/ III		Place of Disposit	ion (Name of ceme	eterv.	Date D1	SCT1CT 120c. Location	He1	ghts, Md. Town, State
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Heath and Mental Hygiene. int: If item 27 is marked other than "natural", or items 23a or 28a-f she rother traumatic event, the Medical Examiner must be notified at once		1 X Burial 2 Cremation	n 3 🗌 Removal f	rom State	rematory or oth	er place)					l, Md.
Baltimore, permit. Pages I ar Department of Hee Important: If ite	-	4 Donation 5 Other Sp 21. Augusture of Funeral Service		wa	Ishing	on Nati	Lonal	5/6/11			•
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traur		21. As letter of Fulleral Service	11 de tu	1	/ 1 1	ame and Address o	or Facility U	niversa	al Mor	tuar	У 20044
Physician	\dashv	23a Part I Enter the disease or	complications that of	aused the death.	Do not enter the	e mode of dying, su	uch as cardiac	or respiratory arr	est, shock, or h	on, D	C 20011 Approximate Interval
/Medical		failure. List only one cause	on each line.					,			Between Onset and Death
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	ner	if any, leading to immediate cause. Enter Underlying Cause		consequence of):						
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	ig	23b. Was decedent pregnant in the past 12 months?	I I LIVE I		2 Feta	aldeath 3	Ectopic pregna	ancy	Month	D	ay Year
Box 687 ne death certific the attending p	Physicia	1 Yes 2 No 9 Unk	known 9 Unknown	nant at time of dea	5 Oth	er (Specify)			344		
E & =	돲	Part II. Other significant conditi			sulting in the un	derlying cause giv	en in Part I.	23e. Did to	bacco use con	tribute to t	he cause of death?
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COT law r has b	힐							autop perfor	med?	prior to co death?	ompletion of cause of
tal Rection: The certificate ector, page	Š.							1 Yes	2 No	1 🗸 Yes	2 No
	<u>ത് </u>	25. Was case referred to medical examiner?	Hospital:				f Death (Check				
1 of Vita ling Physicia After this ce funeral direct	라	1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatient 28b. Time of Inj			g Home 5	Residence 6		Scene
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Division 12 or Atteodic 13 after death. 24 Director: A led in by the fu	<u>icat</u>	2 Accident Inves	May 30,		2334 hrs me. farm. street	factory, office buil		28f Location (S	Street and Num	er or Rur	al Route Number, City
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Division To the Hospital or Atteod within 24 hours after death To the Funeral Director: completely filled in by the 1			miner:On the basis	of examination an							
F # # 8	¥	29b. Signature and title of certifie	and manner s	lateu.		29c. License r	number		29d. Date sign	ned (Mont	th, Day, Year)
		Calal	Hille	lan		O.C.M.	E.		May 31, 2	011	
3		30. Name and address of person	who completed caus	se of death (Item 2	23a)						
		Carol Allan, MD Ass	sistant Medical			more Street, B	altimore, M	D 21223			
Sta	-	31. Date filed (Month, Day, Year)	32. Re	egistrar's Signatur	and I				· · · · · · · · · · · · · · · · · · ·		
Registr	alf	JUN 0 8 2011	Mayer	1. 7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05/31/2011 Year IO: OL AM James Larry Fountain, Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince Georges Clinton **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 **X** M 2 \square F Hours **Director** 212-96-8706 DC Usual Residence of Decedent 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f prince Georges Springs MD Camp 1 X Yes 2 No 10e, Street and Number ò 10f, Zip Code 10g. Citizen of What Country? must be r Funeral 20748 5918 John Adams Dr. "natural", or items . Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Earl; If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Montgomery College Counselor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lucretia Perrin James L. Fountain, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, James L. Fountain, Sr./father 5918 John Adams Dr., Camp Springs, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important; If ite any Injury or ot once. 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harmony Memorial Cem Ob/07/2011 Landover, MD Sign ture of Funeral Strvi to License 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD20748 PALE There the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death GASTROINTESTINAL HEMORRHAGE Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of, cause. Enter Underlying ending physician and use as the burial-transil Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ KIDNEY FAILURE, DABETES MELLITUS Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform To the Hospital or Attending Physician: The certificate 1 🗌 Yes 2 🗌 No Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ♣No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 KInpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending death. Accident Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) ATTENDING PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOUS ROAD #205. GLENN DAVE MD MUSA MOMOH MD, 12150 31. Date filed (Month, Day, Year) State JUN 0 8 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 4:25 A^M 06 07 2011 Myrteena Ruth Fleet /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Manor Care If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Social Security Number 6. Sex **Funeral** Days Hours 1 □ M 2 □ TeF 02/18/1925 Washington, Director 86 577-36-0767 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State 10b. County 1 kg Yes 2 □ No DC Washington Director None 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a or dical Examiner must be r USA 20019 853 51st Street NE Completed by Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or the any injury or other traumatic event, the Medical Examiner once. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DC Government <u>Administrative</u> Clerk 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Selena (Unknown) Samuel Hawkins ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11308 Castlewood Court Laurel, MD 20723 Hazel Sidberry/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/13/2011 Suitland, MD Cedar Hill 22. Name and Address of Facility Marshall-March Funeral Home 21. Signat 4308 Suitland Road Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Examiner 12875 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed 10 physician and is the burial-trans Division or Vital Records, P.O. Box 68760, derangemen Physician/Medical attending properties of the second se as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year in the past 12 months? Day ☐Yes 2 No ed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2 No ate has page 2 s this certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl on Other: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 28c. Injury at Work? 27. Manner of Peath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: After (Month, Day Year) Injury 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, State Registrar

29b. Signature and title of certifier

anove es 32. Registrar's Signature

#B

29c. License number

Greenbe

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

amend#4, 20bperfhg916, 6-22-11 d.o.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ERVIN FORMAN Month Day Year PM 9.15 Medical HINE 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WILLIAMSPORT RETIREMENT VILLAGE WILLIAMSPORT WASHINGTON ocial Security Number Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 8/15/1930 7. Age (In vrs. last birthday) If Under 9. Birthplace (State or Foreign **Funeral** 410-42-2322 XX M 2 □ F Hours TENNESSEE Director 80 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director WV BERKELEY MARTINSBURG 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 106 GRACE AVENUE 25404 USA Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces Black White etc. Completed by 1 Never Married 2 Married 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. item 27 is marked other than "natural", or other traumatic event, the Medical Examir 1 Yes Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify:WHITE 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWNER/OPERATOR HOME BUILDING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ MARSHALL ED FORMAN PEARL RUTH GRADY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TRACY BUTLER/DAUGHTER 92 SHETLAND HILL DRIVE, MARTINSBURG, WV 25404 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) VE 18 2011 2010 SMITHSBURG CREMATORY SMITHSBURG, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 20 327 W. KING ST MARTINSBURG. WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ NELMUNIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 2 No the g Unknown g Unknown as been signed by: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISEAS E 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has I page performed? Yes 2 No 1 Yes 2 🗌 No Be (25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🔲 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 2 Accident 5 Pending 1 Yes 2 No Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifig 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOWE WILLIAMSPORT IED E 154 N. ARTIZAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 2 2011 Registrar

Guillermo Garcia Garcia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 9962

State of Maryland / Department of Health and Mental Hygiene

1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day May 29, 2011 0215 hrs **Medical Examiner** Guillermo Garcia Garcia 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** 1330 A Reisterstown Road 5. Social Security Number 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State or 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Director Hours none 29 04/15/1982 Country) Mexico 1 XM 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore 1 Yes 2 No Maryland imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3935 Clarks Lane #C 21215 Mexico Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 XMarried Yes If Yes, Give Year 3 Widowed 4 Divorced 1X Yes 2 No specify: Mexican Specify: White ੬ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Landscaping Grass Busters 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Garcia Silva Be Eva Garcia Rodriguez 19a. Informant's Name/Relationship (Type, Print) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Baltazar Campos (Friend) 3935 Clarks Lane #C Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Valle Guanajuato, Mexico 1 X Burial 2 Cremation 3 Removal from State 06/11/2011 de Santiago Donation 5 Other Specify: 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature of Funeral Service Licen MU 9013 Annapolis Rd Lanham, Md 20706 23a. Part I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line (Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and ician/Medical UNPENDED AMENDED ending physician use as the burial Box 68760, 23d. Date of deliver 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Month Fetal death Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Physi 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. á 1 Yes 2 No 3 Probably 4 Unknown Completed Records, s been s 24a Was an Were autopsy findings available prior to completion of cause of has performed? death? page Yes 2 No 1 Yes 25. Was case referred to medical 26 Place of Death (Check only one) Be of Vital examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene After this 1 Yes 2 No 28c. Injury at Work? Manner of Death 28a. Date of Injury 28b. Time of Injury 28d. Describe how injury occurred May 29, 2011 Subject shot Natural 0000 hrs Division 1 Yes 2 ✔ No 5 Pending in by the Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City within 24 hours after To the Funeral Dire 3 Suicide Could not be or Town, State) 1330 A Reisterstown Road , Pikesville , MD (Specify) Parking Lot determined 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c License number June 8, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State Registra

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 3. Time of Death 12:01 p_M 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Evelyn Gaskins-Harrison 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Leonardtown Mary Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖵 F Months Days Hours (Month, Day, Ye 63 577-64-9082 Director DC January Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 No St. Mary's Bushwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 36899 Skyview Drive 20618 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S Government Financial Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h မ Florence Dorsey Louis Queen permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence Queen/Mother 36899 Skyview Drive, Bushwood, Maryland 20618 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Maryland Veterans
Cemetery @ Cheltenham 1 🔀 Burial 2 🗌 Cremation 3 🖳 Removal from State June 13,2011 4 Donation 5 Other (Specify) Cheltenham, Maryland Signature of Funeral Service Li 22. Name and Address of Facility Pope Funeral Homes, P.A. MD1085 5538 Marlboro Pike, Forestville, Maryland 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition recovaten Medical resulting in death) Due to (or as a nsequence of) **Examiner** Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 XiNo
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown n signed by the a ld be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sinn Records, 1 Yes 2 No 3 Probably 4 Unknown To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should Is 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No Yes 2 No **Division of Vital** Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 100 Other: 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Vatural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD mo-060 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 02:59AM HARVEY F. GREENAWALT 2011 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death **Examiner** Salisbury Peninsula Regional Medical Cnt 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Delaware Days Hours 1932 Director <u> 178-24-2013</u> 79 ıral", or items 23a or 28a-f shov I Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🛛 No VA New Church Accomack 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 23415 33061 Taylors Cove Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mail Carrier Postal Service uld be filed with Mental Hygier 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Regan Harvey W. Greenawalt and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23415 33061 Taylors Cove Road, New Church, permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Doris Greenawalt/ wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) June 8, 201 Salisbury, MD Salisbury Crematory 22. Name and Address of Facility Pocomoke City, MD 21851 Holloway Funeral Home, P.A., 107 Vine Street CFSP 21. Signature of Funeral Service Licensee MUIJAG 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final -Priysician/ ATHEROSCLEROSIS DRONARY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to jor as a consequence of cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒No 24a. Was an has performed Yes 2 After this certificate I 25. Was case referred to medica 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work 1 Yes 2 No neral Director: A Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire

DHMH 17 Rev 7/2009

Registrar

State

Medical

29a. Certifier

(Check

SHARAD

31. Date filed (Month. Day

only one)

29b. Signature and title of certific

R

JUN 08

Barke

1604 MARKET

MI

Registrar's Signature

MO)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SATYAL

2011

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

62172

POLOMOKE CITY

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1- State AMEND#22 per FH 06/9/2011 TT Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 5, Day 2011 ear Catherine Albertine Julienne Henseler $6:25A_{M}$ **Physician** /Medical 4c. County of Death
Prince George's 4b. City, Town, or Location of Death Hyattsville 4a. Facility Name (If not institution, give street and number) Examiner 5208 42nd P1 Birthplace (State or Foreign Country) Security Number 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** 6MB-P1991 578-06-8796 1 □ M 2 1 F 59 France Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or Items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Hyattsville MD Prince George's Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20781 USA 5208 42nd Place "natural", or Items 23a within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 White Specify þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 2_{yrs} <u>Teacher</u> Private Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Denise Roulliaux Jean Deroff 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Henseler/ Spouse 5208 42nd Pl. Hyattsville, MD Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Ft. Lincoln Cem. Bladensburg, 1 Burial 2 □ Cremation 3 □ Removal from State 6/11/11 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Prince George s Pridgen Funeral Svc 9013 Annapolis Rd. pa & mate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or irijury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transit HTN and Due to (or as a consequence of): Box 68760, physician Physician/Medical certificate use es the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month jo Year in the past 12 months? 1 ☐ Yes 2 🗷 No Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. been signed by the should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an page 2 autopsy performed? 1□ Yes 2 No has certificate Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

T Milli

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Gallant Fox Ln#126 Ba

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Year 8:40 Pm JUNE 4, 2011 ANNETTE **JACOBS** С. /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign WASH., DC 7. Age (In yrs. last birthday) Funeral 1 ☐ M 2 ☐ F Yrs. 579-64-2833 63 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits en "neturel", or items 23a or 28e-f show Medical Examiner must be notified at 1 X Yes 2 □ No Director DC WASHINGTON 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 107 - 33RD STREET, N. E. 20019 U.S.A. Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Rece - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) The state 12TH GRADE ADMIN. CLERK DC PUBLIC SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) nd Mental 1 **JACOBS** HIRAM ANNA SULLIVAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a : if item 27 is ANNA S. JACOBS / MOTHER 107 - 33RD STREET, N. E. WASHINGTON, DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ō Department of Importent: if any injury or once. FT. LINCOLN CEMETERY 6-15-2011 BRENTWOOD. MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. 524 - 8TH STREET, N. E. WASH., DC 20002-5236 TLA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY ARTERY DISEASE 10 YRS. /Medical Due to (or as a consequence of): Examiner CONGESTIVE HEART FAILURE 5 YES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit DIABETES TYPE TWO 10 YRS. Due to (or as a consequence of): by Physician/Medical the as use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the at 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OBESITY 1 Tes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? res 2 X No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2XXER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

withIn 72 hours after

Pages

certificate be executed

attending

After

Director:

hin 24 hours a Hospitel

death.

0

Box 68760

P.O.

Division of Vital Records,

Baltimore, Maryland 21215-0036

State Registrar

Medical

31. Date filed (Month, Day, Year) JUN 0 8 2011

10

15245 SHADY GROVE ROAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

SUITE 130 ROCKVILLE, MD 20858

enn

29c. License number ₱RO96053MD CRNP 29d. Date signed (Month, Day, Year)

06/06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day08 2011 06 04:25 AM James Jones Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ceci1 Union Hospital E1kton Social Security Number . Sex 1 M 2 □ F If Under 1 Year **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min. 0870771929 Director 81 NY 115-20-8640 Usual Residence of Decedent items 23a or 28a-f show 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Ceci1 Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 30 Mill Pond Drive 21911 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. ō 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates. 1950-75 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Navy Personnel other 1 Be permit. Page 1 and 2 should be filled Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alice McGuire Vincent Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Mill Pond Drive, Rising Sun, MD 21911 Norma Jones / spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify Arlington Nat. Cem. 07/27/2011 Arlington, VA Signature of Funeral Se vice Lic 22. Name and Address of Facility R.T. Foard Funeral Home, PA 111 S. Queen St. Rising Sun, MD 21911 Part 1. Enter the dis __e, or complication so nat caused shock, or heart fail. e. List only one cause on each line. hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death sophageal Cancerwith Metastasis Immediate Cause (Final Physician/ disease or condition resulting in death) Unknowity Medical Due to (or as a consequence of) Examiner Sequentially list conditions, If any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: မ 1 ☐ Yes 2 ☑ No Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manne of Death 28h Time of 28c. Injury at within 24 hours after death

To the Funeral Director: After completed filled in by the funer 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Name Practionar I. In the state of the cause (s) and manner stated. Medical 29a. Certifier (Check Certifying Norma Practioners To the best of my knowledge, d. 29b. Signature and title of certification 20023322 6.8.2011.

State Registrar

DHMH 17 Rev 7/2009

20 HVA

31. Date filed (Month, Day, Year)

126A, E thigh

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. S. SACHDEV M.D. IRGA, E HIGH S

11-04461 Brad Allan Jenkins

Please Type or Print in Black Indelible Ink. Ensure All Copies Are L	egible,	19968
State of Maryland / Department of Health and Mental Hygiene	2011	19000
Certificate of Death	Pag No	

		1- For State Certificate of Death Registrar		j. No.									
Physici Nedical Exami	an/	Decedent's Name (First, Middle,Last)	Date of Death Month	Day Year	3. Time of Death 2129 hrs								
neulcai Exami	mer	BRAD A. JENKINS 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dear	June 13, 20	11 4c. County of Deat									
		13215 Budds Landing Place Charlotte Hall		Charles									
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hi		(MM/DD/YYYY) 9. Bi									
Director		575-37-318 11X M 2 F 27 Yrs. Months Days Hours Mi	in. 10-2	0-1983 Forei	ountry) MD.								
J.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits								
OW Any					1 Yes 2 No								
uyland ta-f sh	ctor	MD CHARLES CHARLOTTE HALL 10e. Street and Number	109	g. Citizen of What Cou									
he Ma ified	Director	13215 DUDDG LANDING DIAGE	Ε.										
ath with the Maryland Items 23a or 28a-f sho ist. be notified at once.		13215 BUDDS LANDING PLACE 20662 11. Marital Status 12. Was Decedent Ever in U.S. 13. Wes Decedent of Hispanic Origin? (\$\frac{1}{2}\$)	Specify Yes or No-		rican Indian, Black,								
death or iter	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerl	to Rican, etc.)	White, etc.									
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5-0036 led within 72 hours a Hygiene. other than "natura the Medical Examin	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		16b. Kind of Business	rindustry								
356 thin 7: than than	Completed	12th MOTORCYCLE RACER		SELF									
5-0 led wi Hygier other		17. Father's Name (First, Middle, Last) 18.Mother's Name	ne (First, Middle, Ma	aiden Surname)									
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	RANDALL GLENN JENKINS ANDRE	A RENEE	CAIL									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed withn 72 hours after death with the Maryland Department of Realth and Mouth Be filed within 72 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	٢	19a. Informant's Name/Relationship (Type, Print) RANDALL JENKINS-FATHER 19b. Mailing Address (Street and Number or 29263 PEACE RIVER											
and 2 and 2 fealth traum		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	Town, State 3398								
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 X Cremation 3 Removal from State crematory or other place) METROPOLITAN CREMATORY 6											
litin nit. Partme artme sortan		21. Signature of Funeral Service Licensee MOOJ79 (22. Name and Address of Facility			4.								
Dep Des		RAYMOND FUNERAL SERVICE, P.A. LA PLATA MARYLAND 20646											
Physician		failure. List only one cause on each life.											
/Medical examiner	Ш												
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	Jer	if any, leading to immediate Due to (or as e consequence of):											
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Division of Vital Records, P.O. as or Attending Physician: The law requires that the art death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Completed by		24a. Was ar		utopsy findings available								
cords, law requir	ed l		autopsy	prior to	completion of cause of								
tal Rec	힝		1 ✓ Yes 2		es 2 No								
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ion c ttending leath. tor: Af	ţ	Natural 5 Pending fd 6-13-11 fd 9:15 pm 1 Yes 2 X No	Unknown										
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Divisor Aspital or Annual after Incertal Direct of Filled in the Control of Filled in the Contro	Certification:	4 Homicide determined (Specify) Residence	or Town, Sta	te)13215 Budd ce Hall_Md	is Landing P1.								
Division of Vital Records, P.O. Box 68760, To the Hoppital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Romeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an	d due to the cause	s) and manner as stat									
To th within To th compl	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.											
	2	29b. Signature and title of certifier O.C.M.E.		29d. Date signed <i>(M</i> o June 14, 2011	nin, ⊔ay, Year)								
6		30. Name and address of person who completed cause of death (Item 23a)											
2		Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	ore, MD 21223										
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature											
Regis	trar	MIN 2 2 2011 Peneura B. Againe											

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarAmend#7PerFHPGC6-20-11cr Certificate of Death 2. Date of Death 3. Time of Death Physician/ Day P^{M} AUSTIN MALIK LACY JUNE 2011 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NATIONAL INSTITUTES OF HEALTH BETHESDA MONTGOMERY Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 2/16/1992 1 X M 2 D F 19 18 Months Days Min. Director 610-62-8444 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No CA Los Angeles Altadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 373 West Laun Street 91001 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced **Black** Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic more. Elementary/Seconday (0-12) College (1-4 or 5+) Student Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Darryl Lacy Karen Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Rogers/Mother 86 East Mariposa Street, Altadena, CA 91001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1. ☐ Burial 2 ☐ Cremation /3 🛣 Removal from State Mount View Cemetery June 11,201 Altadena, California 4 ☐ Donation 5 ☐ Other (\$pecify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, MD 20747 Part 1. Enter the disease, or confolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ Multiorgan disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if a y, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to the as a presented on of Empyema or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician be detached for use as the burial Mesotheliona by Physician/Medical Metastatic Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🗷 No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 🗔 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. injury at 28d. Describe how injury occurred 1XNatural 5 Pending after death. 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be the To the Hospital or Atter within 24 hours after de: To the Funeral Director completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 24072 June, 03, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAGEODRN, Scott M.D. BETHESDA, MARYLAND 20892 10 CENTER DRIVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

		•	State Registrar		Cer	tificate of E	Death	R	eg. No.	
	Dhysisis		1. Decedent's Name (First, Middle, La	st)				Date of Deal Month,	Day Y	3. Time of Death
	Physicia /Medic	al	Ethel	Edith (Pratt)	Lease			06	- 14-21	
	Examin		4a. Facility Name (If not institution, given	e street and number)		4b. City, Town, or			4c. County of	
-			Lions Center	7 8 //	o to a thirth day)	Cumber of Year	eriand If Under 24 Hrs.	8 Date of Birth	Alleg	Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 217-10-4754 Usual Residence of Decedent	1 M 2 X 95	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Oct 29	9, 1915	Country) WV
	land ow	ı	10a. State 10b. County	10c. C	City, Town or Loc	ation				10d. Inside City Limits
	Mary Ff sh	ţċ	MD Alle	gany	Cre	saptown				1 □ Xes 2 □ No
	or 28g	Director	10e. Street and Number			10f, Zip Code		1	10g. Citizen of Wh	
	23a c	al	13708 Cecil Ave	enue			21502			SA
	ems	Funeral	11. Marital Status	12. Was Decedent Ever in (Armed Forces?	U.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,	American Indian, White, etc.
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evandor or ust be multiped at	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 ∐ X io If Yes, Give Year or Dates:	1	∐Yes 2.∭XNo	Specify:		Specify:	white
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ryla	should band Ment s marked umatic e	ပ	Michael Pratt		10h Mailin	g Address (Street a				tate. Zip Code)
Baltimore, Maryland 21215-0036	nd 2 shouth and 27 is mirranm.		Arlie Lease	son	16	220 McM	ullen High	way Cur	nberland	MD 21502
re,	iges 1 and 2 nt of Heatth it item 27 i or other tra		20a. Method of Disposition	20b.	Place of Dispos	sition (Name of natory or other place	e) 1	Date	20c. Location - C	ity or Town, State
E O	Page: nent o nt: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Denation 5 ☐ Other (Spec	Hemoval from State C		morial Park		6/18/2011	Cumb	erland MD
alti	permit. Pages 'Department of H Important: If ite any Injury or of		21. gnature of Fineral Service Lice	nsee	22	. Name and Addres	s of Eacility elli Funeral H	ome, PA		
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			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the de one cause on each line.	ath. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
1	Physician	li	Immediate Cause (Final disease or condition	a. Atheroscler	rotre	candiova	iscular	disea	re	6 months
1	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):					
		e	Sequentially list conditions,	b. Due to (or as a const	equence of:					
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o,	an an		resulting in death) Last	Due to (or as a conse	equence of):					
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	ertific ding p		IF FEMALE:	220 If you gutooms of pres	inanov.				and Date	of delivery
Вох	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	etal death 3	Ectopic pregnanc	у		Mont	of delivery th Day Year
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٠ <u>. </u>	that ned b deta	by Pr	Part II. Other significant conditions	contributing to death but not re	esulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contrib	oute to the cause of death?
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900	e law re has bee e 2 sho	plet						24a. Was autop		ere autopsy findings available ior to completion of cause of
ž	m <u>r</u> o	Completed						perfo 1 ☐ Yes	rmed? de	eath? □Yes 2 XNo
ita	yslcian; The is certificate director, pag	Be C	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	nne)	
<u>}</u>	di is	မ	1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpatient 2			42 Nursing H		dence 6 ☐ Othe	
Division of Vital Records,	fing F	jon:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Worl	yat <br Yes 2 □ No	28d. Describe i	how injury occurre	u
isi	Attending ir death. ector: After by the fune	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Injury - At	home, farm, str		163 2 1140	28f. Location (Street and Numbe	r or Rural Route Number,
Ω	after after Dire	Certification:	4 ☐ Homicide determine	building, etc. (Spe	ecify)			City or Tox	wn, State)	
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying I	Physician: To the best of my kaminer: On the basis of exam	nowledge, deat	h occurred at the time	me, date and place	, and due to the	cause(s) and mai	nner as stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical	one)	and manner stated.						
	To To	Σ	29b. Signature and title of certifier	101- 1	10	29c. Licens	NEE 2	75	zad. Date signed	(Month, Day, Year)
	Mr. i		· wower	mu "	11)	Driet)		ペン	June 1	7,2011
	02,		30. Name and address of person wh	c Shin 9	25 B.3	1 /	25h Rd.	Cumb	erland	MD21502
	Sta	te	31. Date filed (Month, Day, Year)	2 32. Registrar's Sig	pature	0		V	(
	Registi		JUN 2 2 2011	32. Registrar's Sig	ave -					

Ethel Lease

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 CATHERINE June 5:09 IRENE LININGER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick Social Security Number 8. Date of Birth **Funeral** . Age (In yrs. last birthday 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F 218-38-2580 Months Days Hours May 13, 1940 **Director** 71 Maryland Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick 28a-f Frederick 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code ems 23a or must be r 10g. Citizen of What Country? Funeral 512 Pearl Street 21701 United States of America items ? . Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
tant: If item 27 is marked other than "natural", or items luny or other traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 ☐ Yes If Yes, Give Year or Dates 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Ness Elizabeth Goldie Nausbaum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William M. Lininger / Husband 512 Pearl Street, Frederick, Maryland 21701 20a. Method of Disposition Department of H Important: If ite any injury or otl 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery June 20, 2011 Frederick, Maryland 4 Donation 5 Other (Specify) Name and Address of Facility

Keeney & Bastord P.A. Funeral Home

106 East Church Street, Frederick, Maryland 21701 MO1433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ holJm MON disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 Yes 2 No Yes Hospital or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this Certificate: Manner of Death 28a. Date of injury (Month, Day, Year, 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 🗌 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 🗍 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) MDD35106 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 West Seventh Street, Frederick, Maryland 21701 Myung Hee Nam, M.D. 32. Registrar's Signature 31. Date filed (Month State Registrar

Anthony Stevens McKelvin

Please	Type of Print in Black Indelible ink. Ensure Al	i Copies Are	Legible.	21	\cap
	State of Maryland / Department of Health and M	ental Hygiene		E	U

		T- For State Registrar				Certific	ate of	Death					Reg. No.				
Physicia		1. Decedent's Name (First, M	ddle,Last))							- 1	Date of De Month	Day	Yea	,	3. Time of Death	
Medical Examir	ner	A n thony	Ste	vens	McI	Kelvi	n					May 31,	2011	Tea	'	0011 hrs	
		4a. Facility Name (if not instit	ition, give	street and num	nber)		4	b. City, Tow	n, or l	Location o	of Death		4c	County of	f Death		
		1306 Rollins Avenu	е					Capitol	Heig	hts			P	rince G	eorge	's	
Funeral	7	5. Social Security Number	6. Sex	(17	7. Age (In	yrs. last birt	hday)	If Under 1	Year	If Unde	r 24Hrs.	8. Date of B	irth (MM/	DD/YYYY	9. Birtl	hplace (State or	
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s 23	uneral	11. Marital Status		12. Was Dece	dent Ever	in U.S.	13. Was	Decedent of	of Hisp	panic Orig	in? (Spec	ify Yes or N			- Americ	an Indian, Black,	
ath v	e e	1 X Never Married 2	Married	Armed For				es, specify C						White	, etc.		
er de	<u> </u>	3 Widowed 4	Divorced	1 Yes If Yes, Give Year	2 X	No	1	Yes 2 X	No	snecify:				Specify:	bl	ack	
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nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. it: If item 27 is marked other than "natural", or items 23a or 28a-f shool other traumatic event, the Medical Examiner must be notified at once.	- -		иет	V T 11-1110												Md.207	46
F. Hear First		20a. Method of Disposition 1 X Burial 2 Crema	ion a l	7 Domewal from			of Disposit ory or oth	tion (Name o	of cem	netery,	[Date	20c. l	ocation -	City or	Fown, State	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-fahor other traumatie event, the Medical Examiner must be notified at once	H			Removal from	m State				tio	ona 1	6/6/	2011	l s	uitl	and	, Md.	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other that injury or other traumatic event, the Medical	J		arti	and the same of th													
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Physician Medical	4	failure. List only one ca	se on eac	th line.				oo do o. o.	,g, -			30p.: a.to. y		.,, ., ., .,		Between Onse	
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Sox 687 feath certific e attending for use as t	.룡I	past 12 months?			nt at time			er (Specify)			p.og.idi.o	,				-,	
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tal Recitant The certificate		25. Was case referred to med	ical					26.F	Place	of Death (Check on	ly one)					
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Division of Vital Records, tal or Attending Physician: The law requirers after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be	[]	1 Notusel	ending	FOUND:	Day,Year)	FOU	ND:	1	7 Y	es 2 🗸	ls:	ubject sh		•			
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DHMH 17 Rev 1/2001 OCME 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Fred M. Morris June **2011** 25A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Bethesda Bethesda Health Rehabilitation Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** Days Hours (Month, Day 08/21/ Washington DC Director 577-48-9690 73 1937 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified Md Montgomery Bethesda 1 X Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 5721 Grosvenor Lane 20814 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than 12th College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the I Self Employed Vendor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry C. Morris Frances Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Y. Skinker(Sister 5032 6th Place NE WashingtonDC20017 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 🛚 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham Vet CemJune 15 11Cheltenham <u>Maryland</u> 21. Signature of Funeral S Ice Lice 22. Name and Address of Facility DC 20011 Tyrone J. Young 719 Kennedy StreetNWWash nplications that caused the deat on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. F ter the disease, or shock, r heart failure. List Approximate Interval Between Onset and Death Immediate use (Final disease or widition resulting in heath) Physician/ unknow Medical Due to ras a consequence of) Examiner Sequentially list conditions. Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) Unknown rate has been signed by the a page 2 should be detached in 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural the funeral 28b Time of 28c. Injury at 5 \square Pending work 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician; To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp 216 Dino Drive, Burtonsville, MD20866

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Date of Death 3. Time of Death Decedent's Name (First Middle, Last) **Physician** 2 (An /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F 71 229-50-0643 02/07/1940 Director Danville, VA Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show 1. Yes 2 No Examiner must be notified at Director MD Charles County Waldorf 10g. Citizen of What Country? 10f. Zip-Code 10e, Street and Numbe 23a or 6084 Thoroughbred Court 20603 USA Funeral items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 72 hours after ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify Specify: 2 Black. 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Operating Room Technician Memorial Hospital 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked ot Ernest Albert Bass, Sr., Pages 1 and 2 should be Alice Lovelace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sheila A. Mitchell-Bull/Daughter t of Health 325 Ashland Avenue Lawnside, NJ 08045 Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place Danyille Memorial Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 06/11/2011 | Danville, VA 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licenses 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Corona vere **Physician** al disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to for as a consequence of if any, leading to immedia cause. Enter Underlying Cause (Disease or injury use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. physician Physician/Medical requires that the death certificate be nding _I IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mont Ectopic pregnancy Day Year Month 5 Other (specify) Pregnant at time of death be detached P.O. the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 3 Records. 2 No 3 Probably 4 Unknown 1 🗌 Yes should ! Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has No No 1 Yes Division of Vital 26. Place of Death (Check only one Physician: 25. Was case referred to medica Be examiner Other: 4 \sum Nursing Home Hospital: 2 No 1 Yes Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ၉ this funeral (Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death the Hospital or Attending Pithin 24 hours after death.

The Funeral Director: After the puppletely filled in by the funeral programmes. Certification: 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending 1 Yes 2 No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in the cause (s) and manner as stated. 29a. Certifier Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L VAN

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day JUNE 01, 2011 BARBARA ELAINE MAJORS 01:07A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 F Min 086-44-7454 60 Director Bronx, Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified 1 Yes 2 □ No Maryland Prince Georges Largo 10g. Citizen of What Country? ō 10e. Street and Number 10f. Zip Code items 23a Funeral #63 Harry Truman Drive 20744 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ŏ Completed by 1 Never Married 2 Married Specify.Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 ☐ Widowed 4 🏋 Divorced Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiers Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Human Resources Recruiter Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vivian Henley 2 James P. Majors 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code #10 Walworth Terrace, White Plains, NY 10606 Jacqueline Majors-Myles (sister) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/9/2011 Westchester, NY Ferncliff Cemetery 22. Name and Address of Facility ope Funeral Homes, P.A. Signature Juneral Service Licensee UR \$538 Marlboro Pike Forestville, MD mmm 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ AZ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 month Month Day Year Pregnant at time of death Other (specify) ed by the a detached f 9 Unknown 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of , page 2 nas autopsy performed death? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 THO မ 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the title of certif 29b. Signature And 29d. Date signed (Month, Day, Year) ٥ completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 3, 9:15 P M Richard Alan Medema 201^y1 Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince George's 13905 Amberly Court Bowie Social Security Number If Under 24 Hrs. Hours Min. Funeral 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 8. Date of Birth sex 1 X M 2 □ F Months Days March 8. Director 383-64-4943 55 1956 Michigan Usual Residence of Decedent 28a-f show 10b. County with the Maryland at 10a State 10c. City, Town or Location 10d. Inside City Limits Director notified 1 X Yes 2 No Marylandi Prince George's Bowie ò 10e. Street and Number 10f. Zip Code must be 10g. Citizen of What Country? Funeral items 23a 13905 Amberly Court 20720 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 A Yes 2 No 1982 If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian. ò Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) r than " Elementary/Seconday (0-12) College (1-4 or 5+) Department of Justice 5+Senior Attorney other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked or traumatic ever ဂ္ Peter R. Medema Eunice D. Holtrop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Mary Ann Medema/ Wife 13905 Amberly Court Bowie, MD 20720 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Baltimore Washington 6/7/2011 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Laurel, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician. disease or condition Colon Cancer Medical resulting in death) Due to (or as a consequence of): **Examiner** Metastatic Liver Disease Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed Terminal Illness (Hepatorenal Failure) and -tran that initiated events Due to (or as a consequence of): resulting in death) Last burial physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page performed? Yes 2 X No or Attending Physician: eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 💢 No မ 4 ☐ Nursing Home 5 🖁 Residence 6 ☐ Other (Specify 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Investigation 1 Yes 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29c. License number uman

State

Registrar

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

JUN 07 2011

Surendra Kumar,

31. Date filed (Month. Dav.

D3224

<u>2905 Mitchellville Road Bowie</u>, MD 20716 Suite #102

6/7/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Medical leen 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MANDI Lleg mi 14~14 5. Social Security Number 6. Sex Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😿 F Months Days Hours Min. Country) 216-80-7812 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 55 East Washington Street 21740 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Completed White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Helmick Bertie Riggleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Linda Startzman/Daughter</u> 12431 Mummert Road ClearSpring, MD 21722 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt.Olivet Presby.Cem. 06/08/2011 Hancock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street any / 2 MOO 260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition schene year Medical resulting in death) s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) physician and the burial-transit Exami that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year 4 ☐ Pregnant : 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed this certificate 1 Yes 2 No Hospital or Attending Physician; 25. Was case referred to medical funeral director, Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1----Natural 5 Pending work?
1 Yes 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F 29b. Signature and title of certifie Jen 6, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hay LIVILE ITroll ino MD TITLL NoTI TO 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

2 2 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE 16 2011 Year Physician/ 3:30A M WILLIAM BRUCE MANESS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10556 DEACON ROAD WHITE PLAINS CHARLES If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday) **Funeral** Days Hours Min Nountry) 1 🔀 M 2 🗆 F 217-70-5222 54 Director Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified WHITE PLAINS 1 Yes 2 XNo MD. CHARLES 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10556 DEACON ROAD 20695 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No NA If Yes, Give 1972- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. <u>-</u>0 I LXYes 2 □ No NAVY If Yes, Give Year or Dates.1972-75 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify:WHITE 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Widowed 4 Divorced other than "nature vent, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) CARPENTERS LOCAL #114 Health and Mental Hygiene. CARPENTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) VERNON DEMPSEY MANESS JEAN PEARL PULLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code PATRICIA MANESS-SPOUSE 10556 DEACON RD. WHITE PLAINS, MD. 20695 Page 1 and 2 20a, Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State OUEEN OF PEACE CEM. 6-20-11 4 Donation 5 Other (Specify) Signature of Prineral Service Licensee M00479 ame and Address of Facility FUNÉ MAR 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Liner Unidentifying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 🗌 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Patural 5 \square Pending work' 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and add who completed cause of death (Item 23a) (Type, Print) ess of person 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav AMUE 0810 AM 06 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Mandrin Hospice House Harwood 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Davs Hours Min. Jan. IU. , 1929 Pennsylvania Director 265-28-0882 82 Usual Residence of Decedent show 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Maryland Prince George's Lanham 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? **Completed by Funeral** U.S.A. 9416 Presley Place 20706 Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Year or Dates. 1946-1966 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Computer Analyst C.S.A. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Abraham Newman Regina Severe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Anneliese Newman/Wife 9416 Presley Place, Lanham, Maryland 20706 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Mary land Veterans concerns to the control of the c 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/08/2011 Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) AFIB Examiner Sequentially list conditions Examine if any, leading to immediate

Cause (Disease or iinjury Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 Yes Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other Specific NOR IN 2 No Hospital ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA HOSPILE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1-Natural iniury 5 Pending HUUSE 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) Name and address of person who 31. Date filed (Month State JUN 0 7 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2 Bay 20 I 9:03 pM Annie Pharr Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 12513 Palermo Drive Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Days 4-22-1922 1 M 2 K F Alabama Director 156-22-8954 89 Yrs Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 K Yes 2 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 12513 Palermo Drive 20904 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏝 No Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16h. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Edd Pharr Mary Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick Havard/ Friend 14710 McCann Farm Rd. Woodbine MD 21797 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗔 Removal from State Fort Lincoln 6-9-2011 4 ☐ Donation 5 ☐ Other (Specifi Brentwood Marvland 22. Name and Address of Facility John T. Rhines Funeral Home LLC 21. Signature Funeral Service Liven Pe 3005 12th Street NE Washington, DC 20017 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line mediate Cause (Final Onset and Death Physician/ Atherosclerotic Cardiovascular Disease mease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Type 2 Diabetes Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To enneutre enter to the action of the euCline Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☒ No Day Month Year Pregnant at time of death the 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has bage 2 s autopsy performe death? 1 Yes 2 No After this certificate funeral director, pag 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2 🛭 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA ဂ 4 Nursing Home 5 X Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: ,
completed filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6-1-2011 MD 11580

Registrar

1150 Varnum Street NE Washington DC 20017

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abbas Motazedi

JUN 0 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 4th, D2 011 12:05 A M Gladys Pharr Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Clinton Southern Maryland Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X F Hours Mir 12-06-1912 North Carolina 98 Yrs. 578-20**-**6037 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f Yes 2 No Maryland Prince George's Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò er than "natural", or items 23a of the Medical Examiner must be Funeral U.S.A 20613 10504 North Keys Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working Veterans Administration life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) (+)Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Lillian Carter Henry A. Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1914 Shamrock Ave, Capitol Hghts, Maryland 20743 19a. Informant's Name/Relationship (Type, Print) Norman Hall / Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Maryland NationalCem. 1 X Burial 2 Cremation 3 Removal from State Laurel, Maryland 4 Donation 5 Other (Specify) 6-11-2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home, Inc. 4308 Suitland Road Suitland, Maryland 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Atheroscienta Cardioves Quar disease disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or) Exami TOURIG attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate ber 24 hours after death.

Funeral Director: After this certificate has been signed by the attending newsivis Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year 5 Other (specify) Month Day Pregnant at time of death signed by the a 1 ☐ Yes 2 t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be funeral director, 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 I R/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29d, Date signed (Month, Day, Year) 2 150669 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANIL KUM MAL MAHAJAN-MD Soynera Manyland Hucpital certer 7503 CURVITED ROAD CLINN MD 10735

State Registrar 31. Date filed (Month, Day, Year)
JUN 0 9 2011

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 14, 2011 Year 12:18 PM Pendergast John Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 13507 Yuma Street Cumberland Allegany 9. Birthplace (State or Foreign Country) MD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** 1 🖳 M 2 🗆 F Months Aud T Director 213-22-2917 81 Usual Residence of Decedent 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director Allegany MD Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 220 Somerville Ave. Apt. 403 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates WW II Specify: 3 Widowed 4 Divorced white 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Celanese Corp. Warehouse Shipping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Michael John Pendergast Mary Katherine Eury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 13507 Yuma Street Cumberland MD 21502 Glenda Daniels daughte 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of 1 A Burial 2 Cremation 3 Removal from State Sunset Memorial Park Important: If any injury or once. 6/18/201 MD Cumberland Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Frühreral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enjer the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic disease or condition resulting in death) 08 Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an performed? 25. Was case referred to medical 26. Place of Death (Check only one) HOME OF examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) DALICHTER 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Natural Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 6/17 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12502 WILLOUBROOK RD 2E-440 CLUMPERIAND, MD 21502 AMAR ZAMANMD.

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JUN 2 2 2011

32. Registrar's Signature

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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 1 Certifying	Physician: (kaminer: On	the basis o	f examina	_										
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M23	Ì	36. Name and address of pers Russell Alexander N		neted cause sistant M				W. Baltin	nore S	Street. Ba	ltimor	e, MD 21	223			
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4		4a. Facility Name (if not institution Queen Annes Emerge		mber)		4b	City, Town, or Queenstow		of Death		- 1	lc. County o Queen A			
Funeral Director		215-82-8264	6. Sex	7. Age (In yrs. 43		yrs.	If Under 1 Year Months Day			8. Date of July	,		Foreign	hplace (State or Intry) Wash.	DC
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Physician Medical Examiner	1	failure. List only one cause on each line. Immediate Cause (Final disease a. Cardiac Arrhythmia due to coronary artery anomaly									Approximate Int Between Onse Death				
		or condition resulting in death) Sequentially list conditions, if any leading to immediate	b. Due to (or as a												
od Sit	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):														
execulian and ial - tra		X UNPENDED	d AMENDED 2	23a,27,	per m	e,g	917 7-1	4-11	sm						
). Box 68760, the death certificate be used to the attending physic ched for use as the burner.	2	23b. Was decedent pregnant in the									ay Year				
ires that the dispense by the detached	3	1 Yes 2 ✔ No 3 Probab													
Cords law requestables been to a should	ounbiere										opsy formed?	pri de		opsy findings ava impletion of cause 2 \(\textstyle{\textstyle{1}}\) N	e of
cian: The certificate rector, page		25. Was case referred to medical examiner?	Hospital: 4 10		,	_		of Death (Other _a					1		-
Physical directions	2 -	1 Yes 2 No 27. Manner of Death	28a. Date o		ER/Outpa 28b. Time		J 10011	y at Work	•			ence 6 iury occurred			
Division of vegical or Attending Phours after death. Beral Director: After the filled in by the funeral		1 X Natural 5 Pendi	(Month, ligation	Day,Year)			1 Y	'es 2	No						
Divis		3 Suicide 6 Could 4 Homicide determ 29a. Certifier	not be	of Injury - At h	ome, farm,	street,	factory, office b	uilding, etc	28	or Town,		and Number	or Rura	al Route Number,	City
To the Hospital within 24 hours To the Funeral completely filled	E C	(Check only 1 Certnying Ph) 2 Medical Exam	ysician: To the best niner:On the basis of and manner sta	examination a			n, in my opinion,	, death occ			e and pl	ace, and du	e to the	cause(s)	
	2	29b. Signature and title of certifier	ell, mis				29c. License O.C.N					Date signed ne 14, 20		h, Day,Year)	
43	1	30. Name and address of person v Pamela E. Southall, MI	·	•	,	900 V	V. Baltimore	Street,	Baltime	ore, MD	21223				
Stat Registra	7.	31. Date filed (Month. Dav Year)		istrar's Signati		ba	KI								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2011 Physician/ Month Charlotte E. Rodeheaver 0305 June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Hospital of Cecil County E1kton Cecil Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Country)
Maryland Hours 1 M 2 X 219-56-5044 62 Director Sept 1949 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🄀 No Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21901 U.S.A. Funeral 43 Wardson Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. "natural", or 1 Never Married 2X Married Ş 1 Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Silvertop Manufacturing (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12)
Twelve Years College (1-4 or 5+) White Marsh, Maryland Project Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Eugene Gerry <u>Jenevieve Mae Kirkendall</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4016 East Baker Avenue, Abingdon, Maryland 21009 Emmett J. Langville Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State West Chester, Pennsylvánia cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State injury or R.A.Ferris & Co., Inc. 06/10/11 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licen ²² Name and Address of Facility A. Parterson & Son Funeral Home, P. Perrvville, Maryland 21903-0766 any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Conset and Death Immediate Cause (Final Gastric Physician/ Medical Cancer disease or condition resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Petal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year signed by the a 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deam occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and Mile of certifie 29d. Date signed (Month, Day, Year) 29c. License number 00023322 Jachders MD

Registrar

DHMH 17 Rev 7/2009

State

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, E thich

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SACHDEN MD

31. Date filed (Month, Day, Year)

126 A

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June Louise 6, 201 Tal Veronica Richardson 6:47 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Columbia Howard If Under 1 Year If Under 24 Hrs. Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🖺 F Year 1945 Washington, DC Months Days Hours 577-58-8582 May 10, 66 **Director** Usual Residence of Decedent 28a-f shov 10a. State items 23a or 28a-f sho er must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Laurel 1 Yes No 10e. Street and Number 10g. Citizen of What Country? Funeral 9895 Palace Hall Drive Apt 308 20723 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 0 by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3℃ Widowed 4 □ Divorced Black Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene.
J other than "
event, the Me School/Public Elementary/Seconday (0-12) College (1-4 or 5+) Bus Driver Transportation other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Alonzo Jones Maggie Wilson Dolores permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any july or other traumatic once. 19a. Informant's Name/Relationship (Type, Prigrand-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shafawn K. Etheridge/ Daughter 716 North Belnord Avenue Baltimore, Maryland 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 6/14/2011 Crownsville, Maryland 21. Signa ore of Funeral Service Licensee 22. Name and Address of Facilit Harry H. Witzke's Family F.H. Inc Ryhomas 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NON-SMALL disease or condition resulting in death) CELL LUNI CANCER DECEMBER 2010 Medical **Examiner** Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or linjury Examine Disability of the season of th and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Dav Year the g Unknown Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed? Yes 2 No Hospital or Attending Physician: The 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Funeral Director: After sted filled in by the funer 1 X Natural 2 Accident 5 Pending death. 1 🗌 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifiei Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier D64395 JUNE 8,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MD 6336 CEDAR LANE COLUMBIA, MO 21044 Registrar's Signature State

Registrar

the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O.

Baltimore, Maryland 21215-0036

thin 24 hours after death.

the Funeral Director: A impleted filled in by the fu

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Certificate:

Medical

Part II. Other significant conditions	contributing to death but not re-	cause given in Part I.		23e. Did tobacco use contribute to the cause of death?						
				1 🗆 Yes 2 🗆	No 3 Probably 4 Unknown					
				24a. Was an autopsy performed? 1 □ Yes 2 7 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No					
25. Was case referred to medical		26. Place of Death (Check only one)								
examiner? 1 ☐ Yes2 🚺 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 □ D0	ome 5 Residence 6	Other (Specify)						
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigati		28b. Time of 2 injury M	8c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury of						
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
(Check 2 Medical Example (Check 2 Medical Example)	ysician: To the best of my know niner: On the basis of examinations arse Practioner: To the best of m	on and/or investigation, in	my opinion, death occurred	at the time, date and place, a	and due to the cause(s) and manner stated					

29c License number

00025640

Ave. H409, Clinton, MD 20735

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)
JUN 0 8 2011

29b. Signature and title of certifier

Khosrow Davachi, M.D. 7801 Old Branch

Danace

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11-04433

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ose R. Saldana	State of Maryland / Department of Certificate of Registrar		ygiene Reg. No.	
Physician/	Decedent's Name (First, Middle,Last)	_	Date of Death Month Day Year	3. Time of Death
ledical Examine	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	June 12, 2011	1404 hrs
	Prince George's Hospital Center	Cheverly	Prince Geo	
Funeral Director	5. Social Security Number 598-24-2271 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min. Min.		Birthplace (State or preign Dominican Country Republic
ly.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca	tion		10d. Inside City Limits
d thow any	MD Prince George's Brentwood			1 X Yes 2 No
the Maryland to 28a-f show tified at occ.	10e. Street and Number	10f. Zip Code	10g. Citizen of What 0	Country?
h the N 13a or potified	4018 Parkwood Street	20722	Dominican	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic evect, the Medical Examiner must be cottlined at socce To GBE Completed by Funeral Director	1 X Never Married 2 Married Armed Forces? If 1 Yes 2 X No	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White, et	merican Indian, Black, c. ispanic
urs after tural" amine	15. Decedent's Education (Specify only highest grade completed) 16a. Decede	nt's Usual Occupation (Give kind of v	vork done 16b. Kind of Busine	ess/Industry
136 hin 72 ho e. than "na edical Ex.	Elementary/Secondary (0-12) College (1-4 or 5+)	nost of working life. DO NOT use reti	TOTE BIN	
5-0036 ed within 72 hour bygiene. other than "natu he Medical Exar	12 Cemeter 17. Father's Name (First, Middle, Last)	ry Maintenance Wo	rker Cemeter (First, Middle, Maiden Surname)	У
21215-0036 uld be filed within 72 hou Mental Hygiene. marked other than "nat c eveot, the Medical Exa C or Be Completed	Ramon Saldana		a Rodriquez	
ID 21215-003 2 should be filed withi and Mental Hygiene. 7 is marked other th matic eveot, the Med To Be Comp		g Address (Street and Number or F	Rural Route Number, City or Town, S	tate, Zip Code)
e, MD 2 I and 2 shou Health and IN Fitem 27 is n or traumatic	20a. Method of Disposition 20b. Place of Dispo	sition (Name of cemetery,	Date 20c. Location - Cit	
10re ages 1 nt of H ft: If it	1 Burial 2 Cremation 3 Removal from State crematory of o 4 Donation 5 Other Specify: Camb It	ther place) Municipal	0-2011 Santo Do	
Baltimore, permit. Pages l an Department of Heis Important: Wite injury or other tr		Name and Address of Facility For	0 2011	
	Lefin prom 4	401 Bladensburg R	oad Brentwood,_	MD 20722
Physician //Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.			Approximate Interval Between Onset and Death
ixaminer	Immediate Cause (Final disease or condition resulting in death) a. Poorly differentiated Due to (or as a consequence of):	metastic gastric	adenocarcinoma	
,	Sequentially list conditions, if any, leading to immediate			
ted nnsit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated			
cuted nd transit	events resulting in death) Last Due to (or as a consequence of):			
60, e be execul ysician and burial - tra	▼ UNPENDED □ AMENDED 23a,27,per me	g916 6-27-11 sm		
68760, ertificate be ding physic e as the bur an/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 21. If yes bitth	- C- ·	23d. Date of deli	•
ox 6876 eath certificate attending phy for use as the tsician/Ma	past 12 months? 4 Pregnant at time of death 5 0	etal death 3	ncy Month	Day Year
D. Box the death coby the attentached for us	1 Yes 2 No 9 Unknown 9 Unknown	4.1.	23e. Did tobacco use contribute	to the source of death?
P. P. S that	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	1 Yes 2 No 3 F	
Records, The law require ficate has been sign, page 2 should bb.				autopsy findings available to completion of cause of
eco he law ate has age 2 s			autopsy prior performed? death	n?
of Vital Records, og Physiciao: The law requir wher this certificate has been someral director, page 2 should n: To Be Completed	25. Was case referred to medical examiner?	26 Place of Death (Check of		
f Vit Physic er this cral dire	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of		g Home 5 Residence 6 O	ther:
ion of teoding Pheath. tor: After the funeral the funeral ation: T	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	200. Describe flow injury occurred	
ivis or At after d Direct in by	28f. Location (Street and Number or or Town, State)	Rural Route Number, City		
the Ho hin 24 h the Fu npletely	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.		• •	
To vit	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	mex	O.C.M.E.	June 13, 2011	
2 1	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Balt	imore Street, Baltimore, MD	21223	
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Month MAY Physician/ 1825 CLIFFORD F. SMITH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S FT. WASHINGTON WASHINGTON HOSPITAL CENTER Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 1 **X** M 2 □ F Days Hours (Month, Day, Country) **Director** Ĩ936 096-28-0453 75 March Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director MD 1X Yes 2 ☐ No Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 203 Battersea Lane 20744 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces?

1 V Yes 2 No
If Yes, Give Black, White, etc. ō 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 H No Specify: **Black** "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **12** Department of H.U.D Management Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filt th and Mental h မ Charles Smith Maude Smith permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 Is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Brenda Smith/ Wife 203 Battersea Lane, Fort Washington, MD 20744 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ memoval from State Riverdale Park Crematory 6/13/2011 Riverdale, Maryland 4 Donation 5 Other (Specify 22. Name and Address of Facility Pope Funeral Homes, P.A. Signature of Funeral Service 5538 Marlboro Pike, Forestville, MD 20747 M01083 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Disease Physician/ Atheroscleratic Coronary disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be eximining a hours after death.

Within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the buring the difference of the pure states and the buring the states of the states are the buring the states of the states are the buring the states of the Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 ☐ Inpatient 2 🗡 ER/Outpatient 3 ☐ DOA 28a. Cate of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: Joy he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) D46741 31 2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 11711 Livington RD, Fort Washington, MD Sachdeva,)cepak 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3, Time of Death Physician/ n L рм 2011 5:15 06 Elizabeth Sheppard Mary Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Bradford Oaks Center <u>Clinton</u> If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. (Month, Day, Director 578-34-9890 89 06/09/1921 Maryland Usual Residence of Deceden or 28a-f show notified at 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 □ No MD Frince Georges Clinton 10g. Citizen of What Country? 5 10e. Street and Numbe 10f. Zip Code ns 23a c must b pe Funeral 9208 Foxcroft Avenue 20735 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Examiner Black, White, etc. . or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎦 No Specify: "natural", 3 M Widowed 4 □ Divorced Completed **Black** Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur jury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Budget Analyst Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Μ. Butler Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Clinton, MD 20735 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Gloria A. Sheppard - Daughter 9208 Foxcroft Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🖾 Burial 2 🗌 Cremation 3 🗎 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 6/10/2011 Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 21. Signature of Funeral Service Licenses 3401 Bladensburg Road Brentwood, MD 23a. Part 1. Efter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Bladder Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events and resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Dav signed by the a d be detached f 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown been signature been s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has by page 2 s performed? Yes 2 K No 1 Yes 2 No certificate 25. Was case referred to medical **Division of Vital** director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🔀 No ၉ 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending ithin 24 hours after death.

the Funeral Director: Ai
ompleted filled in by the fu 1 Yes 2 No death. ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

complete 29b. Signature and title of certifier 29c. License number arme is Melle D35206 June 7, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

William T.

31. Date filed (Month, Day, Year)

JUN 0 9 2011

MD

32. Registrar's Signature

Tanner,

11701 Livingston Road Ft. Washington, MD 20744

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:10 A M Mary Helen Sisson June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Morningside House of St. Charles Charles Social Security Number If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) If Under 1 Year 9 Birthplace (State or Foreign **Funeral** Washington DC 1 M 2XX Months Hours (Month, Day, Year) ug 29, 1916 577 01 3111 Director 94 Aug Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If fine 77 is marked other than "natural" or incention any injury or other trainment. 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No Maryland Prince George's Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17600 Horsehead Road 20613 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 XXNo Completed by 1 ☐ Yes 2XX No Specify: White Specify: 3 🕅 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Operator Chesapeake & Potomac Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Helen Mankavitch Elarion Tatur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph A. Sisson (Son) 17600 Horsehead Road, Brandywine, MD 20613 20a. Method of Disposition

1 A Surial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Cedar Hill Cemetery 4 Donation 5 Other (Specify) June 11, 2011 Suitland, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 old 21. Signature of Funeral Service Licen Alexandira FerryRoad, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month 1 Yes 2 No Pregnant at time of death been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 hknown 24b. Were autopsy findings available 24a. Was an certificate has autopsy performed? prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 27 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Director; After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 5 Pending Natural Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined within 24 hours a To the Funeral D 29a. Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 :57 P June 4 <u>Nancy Elizabeth Sporck</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charles 603 Marshall Court Waldorf Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months 1 M 2 X F Days Hours Min Day, 58 Pennsylvania Yrs **Director** 205-44-8046 1952 Usual Residence of Decedent show 10a. State 10b. County with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X□ Yes 2 □ No Waldorf <u>Marylandl</u> Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 603 Marshall Court 20602 r death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? 1 XX Never Married 2 Married Black, White, etc. ģ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical II once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2+ Courier Quest Diagnostic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Raymer Sporck Phyllis Sleighter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Glessner/ Cousin 603 Marshall Ct. Waldorf, Maryland 20602 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Crematory Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. noo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metustatio disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner N Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hyperi Hospital or Attending Physician: The law requires that the death certificate be executed bunial-transi Cause (Disease or iinjury 101 that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death ☐ Yes ∠ ☐ ☐ Unknown 4 ☐ Pregnam a 9 ☐ Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed Yes 2 After this certificate funeral director, pag 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 🖪 No Hospital: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director. At completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledg, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Practioner: To the basis of my increasing on the course of the time cate and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the I only one) 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) D004049 30. Name and address of person who completed cause of death (Item 23al Type, Print) RBIO Robert Davisa

State Registrar

31. Date filed (Month, Day, Year)

JUN 0 9

12070

old Line Center Svite 100 Walder F MD 20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 201 Tear June STITELY NORMAN I. 11:15 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death K1ine Hospice House Mount Airy Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Days FEB. 17, 1924 Hours Min. 220-16-1596 Mary Land Director 87 Usual Residence of Decedent or 28a-f shov il Hygiene. I other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Thurmont 1 X Yes 2 No ᡖ 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 125 Cody Drive, # 14 21788 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces?

1 X Yes 2 No
If Yes, Give ģ 1 Never Married 2 Married 1 Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12 \end{array}$ College (1-4 or 5+) Government Contracting Officer any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o ပ္ C1vde Stitely Harriett Ruth Spalding | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Stitely / Son 120 Fieldstone Ct./ Frederick, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Blue Ridge Cemetery 4 Donation 5 Other (Specify) 06/06/2011 Thurmont, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 104 E. Main St./Thurmont, Maryland 21788 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MeThATERIC Prostate Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): that the death certificate be executed Due to (or as a consequence of): Physician/Medical ding ! IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Descript at time of death 5 Other (specify) use 23b. Was decedent pregnant 23d. Date of delivery atten for us in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown s been signated the should the Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page certificate 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 X Other Specific House 2 🖪 No 1 \sum Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work?
1 Yes 2 No Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time date and place and place and place.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time date and place and place. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ceptifier 29c. License number 29d. Date signed (Month, Day, Year) 00067691 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7th St. Frederick, MD 21701 Monde G. Goldstein MD 501 AVITO

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Regist ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O. |

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Physician/ Month Υ. Thomas Tammv May 17 9:45A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7224 Lansdale Street District Heights Prince Georges Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛛 F Hours May 24 979 577-02-0755 Director 3 1 Yrs. Wash., DC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD PG District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20747 United States 7224 Lansdale Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14 Bace - American Indian. Armed Forces? Black, White, etc. þ 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Yes 1 Yes 2 No Specify: Specify: Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Caregiver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Valerie Morton John Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7224 Lansdale Street
District Heights, MD. 20747 John Thomas/father 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Lincoln Cemetery 5/27/1 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD e of Funeral Service License 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ Uterine Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. inding physician and use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 month 1 Yes 2 No Month Year Pregnant at time of death Day g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? this certificate has performed? Yes 2 N 1 \square Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) nours after death.

neral Director: After the filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Tes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the pasis of examination allows investigation, it my openion, a coal resource at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kouatchou, ms Mary: 24, 2011

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Physician/ Monus May 6:59 AM 31 Charles J. Thomas Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Prince George's Prince George's Hospital Center Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day,) Months Days Hours Min 54 Missouri Director 499-60-0614 March Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10c, City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20019 1145 46th Place SE 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 X Never Married 2 Married 2 X No Yes 3altimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: "natural" 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Financial Advisor Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Gladys Foster William Thomas Department of Health and Important: If item 27 is n any injury or other traum. Print) Domestic 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter A. George 1145 46th Place SE Washington, DC 20019 Partner 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St. Louis, Missouri Louis Cremation 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home, 20019 4001 Benning Road NE Washington, DC 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ⊋hysician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 use as 1 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death been signed by the s should be detached Unknown g 🗌 Unknown P.0. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 2 🗌 No Yes 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the Hosp within 24 hor To the Fune completed fi Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert completed cause of death (Item 23a) (Type, Print) Date filed (Month, Da State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alvin Taylor, Jr. Month 20 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11714 N. Marlton Ave Upper Marlboro Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign 1 🗓 M 2 🗆 F 246 48 3680 North Carolina 75 **Director** 1936 March 4 Usual Residence of Decedent or 28a-f show notified at sho ld re filed within 72 hours after death with the Maryland and Mental Hyglene.

I are Mental Hyglene is a second secon 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2√ No Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11714 N. Marlton 20772 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian Black. White, etc. þ 1 Never Married 2XX Married 1 Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify Specify: African American Completed 3 Widowed 4 Divorced Year or Dates. Vietnam 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Director of Data Automation Pentagon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alvin Taylor, Sr. Ruth Dancy Page 1 and 2 sho Introduced the International Program International Program International Program International In 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gretchen Taylor (Wife) 11714 N. Marlton Ave, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Sign an e of Funeral Service Lice MO1553 Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate enval Retween Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has performed 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined e Funeral 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

72B12H

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bernard Month Thompson May 7:15PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Charles Gensis of LaPlata LaPlata Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 74 Months Days Min 1 🗶 M 2 🗆 F Washington DC Director 578-50-0590 ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Kensington Montgomery MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20895 USA 3123 - 4 University Blvd. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married þ 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: "natural" Completed 3 XWidowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) 12th Salesman Auto Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Myrtle Grove Thomas L. Thompson Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sł Department of Health a Important: If item 27 is 1008 Ivy Lane Waldorf, MD 20602 Frances M. Schoenbaur/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 3/3/2011 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD 20601 17005 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir sician and burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ___ Live Birth 2 __ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by with behavanal Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypes Thision, Tachi 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Lenp. msu or Attending Physician: The perform 2 No 1 🗌 Yes 25. Was case referred to m **Division of Vital** 26. Place of Death (Check only one) Be examiner' Hospital 2 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending ours after death.

neral Director: Aft
filled in by the fur 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral D completed filled i Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 71190 06/02/2011 30. Name and address of person who completed pause of death (Item 23a) (Type, Prin 2007 Ti dewarter www.jpg.jpg.jpe. eted cause of death (Item 23a) (Type, Print) Annayotis, MD, 21401 7133

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

11-04201 Ashton Termine Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For Stete Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month 1352 hrs Medical Examiner Ashton M. Termine June 4, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death La Plata Charles Civista Medical Center 9. Birthplace (State or 5. Social Security Number if Under 1 Year If Under 24Hrs. 8. Date of Birth/MM/DD/YYYY 6 Sex 7. Age (In yrs. last birthday) **Funeral** Director Country Mary land 1X M 2 F 1997 March 5 14 216-49-9500 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 XX Yes 2 No imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Maryland Waldorf Charles Director 10g. Citizen of What Country? 10f. Zip Code USA 20603 4750 Hummingbird Drive Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 Yes 4 Divorced If Yes, Give Year White 3 Widowed 1 Yes 2 X No specify: Specify: ፩ or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed College (1-4 or 5+) Elementary/Secondary (0-12) Student 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Termine Sherri Folkman ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) She<u>rri Termine/ Mother</u> 4750 Hummingbird Dr. Waldorf. MD. 20603 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Balth, permit. Pag. Department or 'upportant: If is 'up or or' crematory or other place) 1 Burial 2 Cremation 3 Removal from State June 7. 2011 Waldorf, MD. 4 Donation 5 Other Specify. Huntt Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Huntt Funeral Home per DVR/FH Kelli R. Breuer 3035 Old Washington Dr. Waldorf, MD. 20601 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED #21 per fh,g917,07/08/2011dhb ending physician use as the burial -UNPENDED Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Month Day Year 2 Fetal death past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown Unknown s been signed by the should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has performed? death? Yes 2 No 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Pedestrian struck by auto Natural FOUND: 5 Pending 1 Yes 2 ✔ No filled in by the Jun 4, 2011 1306 hrs 2 🗸 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) Route 228 @ SB Route 301, Waldorf, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 5, 2011 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State 111N 0 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMEND# 12 per FH 1 - State Registrar 6/7/2011 AACO HEALTH DEPT. CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Pague Medical 4a. Facility Name (if not institution, give street and jumber) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 ★ M 2 □ F Min. Months Hours \$ept 13 Year 940 Alabama Director 421-46-5456 70 Usual Residence of Decedent 28a-f show 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Maryland Anne Arundel Annapolis 1 Yes 2 X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21401 USA 1701 St. Margarets Rd. death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify: Specify: Black Completed 3℃ Widowed 4 □ Divorced Year or Dates 959 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12th 0 Tax Auditor D.C. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles Teague Sr Lockie Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jan J. Brown(Daughter) 1603 Carry Back Ct. Annapolis, Md. 21409 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or nd Veteran 6/7/2011 Crow Miname Rocesco Scillsons Mortuary, 21. Signature of Funeral Service Licensee any i 21401 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** isease ear ona Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on: sician and burial-transit · Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as the t IE EEMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ jo in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? ģ ronic Obstructive Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed Disease 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No To the Hospital or Attending Prysi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir ၉ ER/Outpatient 3 DOA 1 Inpatient 2 this 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Naturai 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 400 5 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

7

strar's Signature